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The Ethics of Medical Involvement in Capital Punishment

A Philosophical Discussion

Joseph B. R. Gaie

Kluwer Academic Publishers

THE ETHICS OF MEDICAL INVOLVEMENT IN CAPITAL PUNISHMENT

INTERNATIONAL LIBRARY OF ETHICS, LAW, AND THE NEW MEDICINE

VOLUME 18

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THE ETHICS OF MEDICAL INVOLVEMENT IN CAPITAL PUNISHMENT

A Philosophical Discussion

by

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KLUWER ACADEMIC PUBLISHERS
NEW YORK, BOSTON, DORDRECHT, LONDON, MOSCOW

eBook ISBN: 1-4020-2539-4
Print ISBN: 1-4020-1764-2

Created in the United States of America

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and the Springer Global Website Online at: http://www.springeronline.com

This work is dedicated to the Gaie family and all the family friends.

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ACKNOWLEDGEMENTS

I wish to acknowledge the following for their different invaluable contributions without which this work would not have been possible: Godiramang Makhaya, Keikanetswe Monyai, James Amanze, John Parrat, Saroj Parrat, John Melamu, Thomas Tlou, Vincent Botshelo, Innocent Botshelo, Tom Sorell, Will Cartright, John Basimanebotlhe Gaie, Gabriel Gaie, Cecilia Gaie, Ndipo Segametsi Gaie, Joshua Muller Sebopeng, Leah Mosimanyana, Emily Maripe, Joseph Maripe MmaBoitumelo Botshelo and all those unsung heroes and heroines of this world who have silently made profound and yet unnoticeable contributions.

I would also like to thank all those who made it possible for me to write my PhD thesis on which this work is based.

INTRODUCTION

The morality of capital punishment has been debated for a long time. This however has not resulted in the settlement of the question either way. Philosophers are still divided.[1] In this work I am not addressing the morality of capital punishment per se. My question is different but related. It is this. **Whether or not capital punishment is morally right, is it moral or immoral for medical doctors to be involved in the practice?**

To deal with this question I start off in Chapter One delineating the sort of involvement the medical associations consider to be morally problematic for medical doctors in capital punishment. They make a distinction between what they call "medicalisation" of[2] and "involvement" in capital punishment, and argue that there is a moral distinction between the two. Whilst it is morally acceptable for doctors to be "involved" in capital punishment, according to the medical associations, it is immoral to medicalise the practice. I clarify this position and show what moral issues arise. I then suggest that there should not be a distinction between the two.

The medical associations argue that the medicalisation of capital punishment, especially the use by medical doctors of lethal injection to execute condemned prisoners is immoral and therefore should be prohibited, because it involves doctors in doing what is against the aims of medicine. Whilst it might be morally right for non-doctors to execute condemned prisoners, the moral basis of that would be different from medical ethics. So in Chapter Two I deal with the issue as to whether medical ethics is separate from ordinary morality or not. I claim that role morality is a special application of ordinary morality. I make use of Gewirth's "Principle of Generic Consistency". According to this principle every person would like to pursue their own interest and from this arises the right of each to promote such interest and well being. Each has a moral right to pursue their interests without being impeded as long as they do not impede others in the process. Since these interests are pursuable in society with a division of labour, they give rise to roles (professions). Playing a particular role in society should be done in harmony with other people's interests.

I take the examples of business and medicine to argue, that rather than there being moralities particular to each of them, they are examples of means of pursuing interests, and the pursuit of such interests cannot be morally acceptable if it involves the violation or impediment of others' pursuit of their own interests. Thus, a businessman pursues his interest by means of his business. If he is to do so in a morally acceptable manner he should not impede others in the pursuit of their interests. Likewise, medicine is a means of promoting people's interest and well being by preventing their demise through disease. Medicine would be morally problematic if its pursuit violated people's interest and well being.

The application of Gewirth shows that medicine has to give way in case of conflict

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[1] There is a lot of literature on the subject. Sorell (1987) for example thinks capital punishment is justifiable in some cases; Bedau (1967, 1982, 1998) and S. Nathanson (1987) think it is not justifiable.

[2] See the elaborate distinctions between these in Chapter One below.

to institutions that protect moral rights, including penal institutions, where the normal requirements of those institutions clash with the requirements of medicine. If institutions carrying out capital punishment in particular protect rights, everyone, doctors included, may need to assist them.

In Chapter Three I argue that if some cases of euthanasia are morally justifiable, and doctors can euthanise their patients without violating moral principles. The medical role does not necessarily always exclude killing. Therefore assisting at an execution is not necessarily immoral for doctors just because it involves killing. In Chapter Four I look at the military doctor role and argue that even though doctors are not supposed to engage in war, their role supports an institution that may kill people. If we take a war situation, we find that doctors may attend to the health (physical and psychological) of soldiers who can be assigned to go and bomb enemy positions, killing even non-combatants in the process. With his non-combatant status, the doctor can still help in the planning of a military attack by assuring the health of friendly soldiers. The military doctor is also in a position whereby he "repairs" people (soldiers) only to have them go back to face the same dangers again when they are fit for duty in the frontline. It is also notable that throughout history the military doctor role has been very important for the survival of armies. The military doctor role's contribution to war efforts is crucial. Doctors in the army may be at least involved in assisting those who may kill, and such involvement is justifiable, I argue.

Military doctors are not the only medical people who may sometimes justifiably help to kill or help to repair people to face death. Giving the example of the prisoner doctors in the Nazi concentration camps, I argue that there are cases where doctors may ***have*** to kill. In the Nazi prison camps people who were chosen to be killed and prisoner doctors co-operated with the SS, making the process less brutal for the victims.[3] The argument here is that the selection of those to be killed was morally wrong. But the prisoner doctors did it because it was a lesser evil. If capital punishment is morally wrong it might still be a lesser evil to involve doctors in execution by lethal injections rather than not to. What this means is that the medicalisation of capital punishment is not necessarily wrong even if capital punishment itself is wrong. In short, the doctor-executioner role might not after all be incoherent.

In Chapter Five I argue that different medical practices are not necessarily for the interest of all those who are directly affected by those practices. The examples are abortion, where the foetus does not necessarily benefit, and expert medical witness against an accused in a trial. So there is no reason to assume that medical involvement should necessarily benefit the patient. It is also evident that some of the different stages of the capital punishment process that are acceptable may be comparable to those unacceptable to the medical associations. This includes certain practices such as war and the involvement of doctors.

In Chapter Six I say that there is a Kantian argument for the medicalisation of capital punishment, or at least some stages of the process, including the injection itself. Kant holds that capital punishment is morally acceptable. And he holds that those to be executed should not be mistreated in any way so that their human dignity is not violated. I hold that medicalisation can be seen as an appropriate means of attaining execution with dignity.

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[3] See Appendix 1.

In Chapter Seven I suggest that the overall beneficial consequences of medicalisation for those who are executed provide a utilitarian justification for it. This is based on Mill's version of the Utilitarian theory of morality. I will argue not only that the medicalisation of capital punishment is beneficial both to the prisoners and the executioners, but that according to John Stuart Mill; the moral principles of desert may be justifiable if it is useful to apply them. Once we apply the principle of desert, we might find that some prisoners deserve to be lethally injected. It might also show that medical involvement at all the stages of the capital punishment process may be just, and it is therefore useful to uphold justice and maintain all its institutions.

Chapter eight looks at the doctor and their relationship with the condemned prisoner. The condemned prisoner does have a patient-physician relationship because being in death row makes one emotionally, psychologically and rationally ill. In short a death row prisoner is in a state in which there is necessity for a physician. It also suggests that the medical doctor should be involved in capital punishment for social reasons.

Medicine can be shown to be just like any other profession. Or, put another way, other professions seem to demand similar sorts of obligations from their professionals. The history of medicine also shows that it was considered to be just an art. I argue that the difference is that it happens to be an art that is concerned with what human beings take to be sacred—human life, which is why probably medicine is believed to be sacred. I think this is a mistake

CHAPTER 1

MEDICALISATION OF CAPITAL PUNISHMENT

Two arguments are sometimes produced against doctors' involvement in capital punishment. Medical associations advance one of the arguments. It says that whether capital punishment is right or wrong, it is against medical ethics. So while it may be all right for some professionals or others to be involved in capital punishment, members of the medical profession should not be involved. The other argument, from Amnesty International, is not agnostic about the morality of capital punishment. It says that capital punishment is wrong, and therefore no one should be involved. Doctors are not singled out as a morally significant group.

We may distinguish two types of medical involvement that the arguments are against. One type is the "Medicalisation" of the method of execution, as when doctors and other medical professionals administer lethal injections. Another type of involvement is in the capital punishment regime on either side of the process of execution, as when doctors are called upon to give evidence in capital trials, give medical attention to prisoners on death row, or harvest organs from executed prisoners.

I start with the medical associations' definition of medicalisation and medical involvement. Is there a morally significant difference between medicalisation and the involvement of medical professionals in capital punishment? The medical associations think there is. Their distinction may be gathered from the following descriptions of the two processes:

MEDICALISATION

Medicalisation is the process whereby medical techniques are used in carrying out capital punishment. For example, psychiatric techniques of pacifying a nervous and worried prisoner, giving them medicines which calm them down just before the execution, finding suitable veins, determining whether intramuscular or intravenous technique should be used[4] and injecting them with a lethal dosage just as it is done for a patient. This process needs medical knowledge and it requires the involvement of the medical professionals if it is to be done safely. So it means involving nurses, medical assistants, psychiatrists, doctors and other medical professionals.

[4] Pacifying a nervous prisoner just before execution, giving them medicines which calm them down and finding suitable veins and so on may seem to be like other stages of the execution before and after it. The medical associations view all these as part of the execution itself.

CHAPTER 1

MEDICAL INVOLVEMENT IN CAPITAL PUNISHMENT

Medical involvement in capital punishment is when the medical professionals play a role in the process before and after capital punishment, standing back from the execution itself. They may be involved for example in a capital trial by giving medical opinion and evidence during the trial. A psychiatrist may determine for the courts whether a suspect is sane enough to stand trial or not. A physician may testify as to whether a suspect suffers from a disease that may have bearing on the culpability of a suspect. A forensic specialist may give evidence of body fluids and other related matter found at a murder scene. This is involvement in the process prior to the execution itself.

The medical professionals also participate in the process when they have to give evidence at the sentencing stage of a capital trial that may result in the death penalty. They also participate in the treatment of death row inmates as psychiatrists and physicians. Tranquillisation of the prisoner may be necessary for the prisoner in preparation for the execution itself. Such involvement does not include carrying out the execution itself. When death has occurred they certify the fact.

ISSUES ARISING FROM THE DISTINCTION BETWEEN MEDICALISATION AND INVOLVEMENT.

It is with the help of the distinction between the medicalisation of execution and medical involvement in the wider capital punishment process that the medical associations wish to determine what is acceptable for medical professionals and what is not. The medical associations accept, without question apparently, the involvement of their members in the process leading up to execution. Presumably the medical associations think doctors may be involved in the wider capital punishment process because doctors, like other professionals, should contribute something to the legal process. It is also apparent that they think medical professionals have the right, if not the duty, to help society at that level just like other citizens. If they think otherwise, it does not seem to be clear why they do not object to that kind of involvement.

I accept the distinction between medicalisation and medical involvement as a matter of fact but object to the use of the distinction to suggest that one is morally acceptable whilst the other is not. I argue that there is something morally suspect about the view that it is morally acceptable to help other people find reason to execute an individual (in the cases where they help in the conviction of a murderer which then ushers in the process of execution) but not acceptable to kill the individual. This happens when the medical professionals are prepared to give incriminating evidence that might lead to the execution of a criminal, for example at the sentencing stage of a capital trial. When the criminal has been sentenced to death they then back off and claim it is not right for them to be involved.

Once it is accepted that somebody (the government in this instance) has a legitimate right to execute convicted criminals as a matter of justice, then they should help even in medical execution for the same reason that they are prepared to be involved in other

stages of the process. The medical associations reject this argument on the grounds that execution is directly opposed to what the medical profession aims at—saving life—whilst mere involvement in the wider capital punishment process is not. This raises the issue of role morality. Does medicine have a special morality that is different from ordinary morality? I argue that it does not. The role of medicine in society has not in fact been confined to saving life and reducing suffering alone. There have been many instances of medical involvement in activities that shorten human life, for example in the execution of war, abortion and euthanasia. The acceptance of medical involvement in capital trials suggests that at least the medical commitment solely to life saving is not total but that sometimes it is justifiable for them to shorten life.

THE MEDICAL ASSOCIATIONS' POSITION ON MEDICALISATION OF CAPITAL PUNISHMENT

The medical associations argue that medicalisation is against medical ethics. Medicine they argue is for the benefit of the patient, and not the state. I think that medicalisation is for the benefit of the prisoner who may be treated as a special type of patient. The prisoner benefits more from medicalisation than from its absence. There is a utilitarian argument for medicalisation. The main utilitarian reason for medical involvement in capital punishment is the benefit to prisoners; the other argument is from justice. To clarify the issue, let us consider medical involvement at the following six stages of the capital punishment process.

i) Before a capital trial doctors may give evidence regarding the medical fitness (psychiatric and physical) of a suspect to stand trial. The forensic doctors may give evidence that can lead to the arrest of a suspect.
ii) At a capital trial the doctors (forensic, physicians and psychiatrists) may give evidence which may be incriminating.
iii) Once a prisoner is found guilty of a capital offence, doctors may give incriminating or aggravating evidence that may result in the death sentence.
iv) Whilst prisoners are on death row doctors (physicians and psychiatrists) may maintain the health of a prisoner.
v) Doctors may tranquillise a prisoner who is about to be executed if the prisoner requests it.
vi) Doctors may transplant the organs of a prisoner who has willingly donated them.
vii) They may certify the death of an executed prisoner.

All these constitute involvement for the medical associations, and, according to me, they are acceptable. The issue that arises out of (i-iii) and (vii) is that medical professionals are not involved in order to save life or to alleviate suffering. If these things are morally acceptable, there should be a reason for that acceptability other than the saving of life. Medical involvement at this point is not beneficial to the prisoner but all the same it may be beneficial to the wider society. Thus the argument for their involvement is a utilitarian one. There are more benefits in involvement rather than non-involvement of the medical professionals.

Whilst medical professionals in (i-iii) serve justice, they are involved in a process that risks the life of a prisoner in a capital trial. The question then is whether it is in accordance with ethics to endanger the lives of people for the sake of justice. This is rather like asking whether there should be armed police, when that adds to the risk of loss of life among innocent civilians. Just carrying the weapon can be considered to be endangering life but may be justified by the requirement of punishing people for crime. Similarly having doctors eligible to give evidence in a capital trial risks endangering life. The medical associations seem to accept that it is in accordance with medical ethics to endanger life for the sake of justice. I agree and argue that it is because the medical professionals have other duties besides their medical ones, and that has more benefits, and there is no point in denying the danger posed for the prisoner. The medical professionals should take responsibility for the danger posed to the prisoner and argue that it is beneficial on the whole to endanger the lives of capital criminals.

The justification for (iv-vi) is the benefits that accrue to the prisoners, and in this case the justification accords with medical ethics. Here there appears to be a balance between helping the state attain justice while at the same time making sure that the prisoners do not suffer from disease and anxiety. I try to show later on that there are both utilitarian and Kantian arguments for this position. The medical associations would not necessarily share this view, but I suggest that they are wrong.

What the Medical Associations Regard as Unacceptable for their Members to do

a) predict that certain prisoners pose a danger to society in future.
b) treat death row prisoners against their will so that they can be fit for execution.
c) certify prisoners to be fit for execution.
d) tranquillise prisoners against their will before execution.
e) supervise the process and tools of the execution.
f) subdue an unwilling prisoner by medical procedure, so as to facilitate execution.
g) monitor the execution and determine the time of death.
h) carry out the execution (by way of medical procedure) lethal injection.
i) harvest organs of executed prisoners without consent or against their will.

I deny that all these things are impermissible. Specifically, I claim (a) that prediction itself is not wrong in principle, and if doctors can do so accurately there is no good reason why they should not. (b) The treatment of death row prisoners, even against their will, so that they can be fit for execution, raises the question as to whether it is right not to treat people against their will. It may be wrong to treat people against their will, but in the case of a prisoner, it is legitimately not up to them to decide whether they should be executed or not. Likewise, it should not be up to them to decide whether they should be in a condition to be treated in preparation for execution.

I also hold that if governments have the right to punish people by death, and to do so justly, they need certification of the prisoners' fitness. Doctors should be able to certify fitness for the same reason that they do at capital trials. It is not against medical ethics to help a legitimate process to go on. Further, in actual fact doctors do not certify that a certain prisoner is fit for execution. All they do is certify that a certain prisoner satisfies certain standard of fitness. It is the government that determines whether that standard of fitness allows them to execute the prisoner. If unfitness to be executed is an impediment

to justice, and a government would be acting unjustly in executing an unfit prisoner, doctors should help them attain the goal of justice by certifying prisoners' fitness for execution.

Tranquillisation of prisoners against their will in preparation for execution raises the issue of paternalism. Does the doctor know what is good for the prisoner even though the prisoner may disagree? In a way the doctor does. Society has the right to minimise the prisoner's pain even if they want to be left suffering, because doctors have to ensure that the process for everyone is the same and as humane as possible. Furthermore, the suffering of a prisoner who is about to be executed troubles those who execute them. They have the right to do their work with as little trouble as possible and the doctor should help them achieve this whilst at the same time reducing the prisoner's suffering.

A prisoner who is taken to the execution chamber fighting and struggling probably experiences more distress than the one who agrees to go to the execution without a fight. It is more likely that in the process they may get injured or they may injure those who have to execute them. It also hurts the executioners to see the prisoner struggling. Subjugation of the prisoner by medical technique reduces all that pain. So at least on utilitarian grounds it is agreeable that the doctor should help. It is both for the prisoner's benefit and that of the executioners.

The supervision and maintenance of the execution machinery is reasonable. If the machines do not work properly they are most likely going to cause pain to the prisoner and the executioner. If the doctor is the only professionally qualified person to do the maintenance, they should do it. And it is for the good of the patient who is the prisoner.

The monitoring of an execution and determination of time of death by a doctor helps the prisoner because doctors are better than the average person at determining whether the prisoner experiences pain and to what extent. This knowledge helps to refine the procedure in future. It also helps the doctor do research into pain and other issues related to executions. It would be more painful for a prisoner to be left half dead because the executioners failed to detect the vital signs of the prisoner.

It goes without saying that the best-suited person to do a job is one that is most knowledgeable about the job and is able to apply the knowledge well to practical situations. Doctors know medical techniques better than other professionals do. Therefore if execution is to be carried out efficiently, doctors should be the ones to do it. The execution of prisoners by doctors would mean that they take over the duties of executioners. That means a combination of the two roles. There is not necessarily a problem with this, because it is normal for roles to be combined. The moral issue that arises from the doctors becoming executioners is whether it is right for doctors to do what apparently is the opposite of their aim to save life. I suggest that it can be.

Organ harvests and transplants from executed prisoners raise the issue of whether it is right not to use somebody's organs against their will. If society has lost something in the death of the prisoner's victim, the use of their organs to save or improve some members of society is a kind of compensation to society. It might not be a terrible wrong to force prisoners to donate their organs once it is accepted that on murdering their victims, the prisoners have lost claim to a lot of rights, including that of withholding consent to donate their organs. Few would deny the benefits of organ donations and transplants.

ROLE MORALITY

The medical associations' objection to medicalisation is that it is against medical ethics, though not necessarily unethical when carried out by people outside the medical profession. The question then is whether the standards of medical ethics are separate from general ethical standards. I argue that medical ethics is not separate. It is a part of the general ethics such that behaving in accordance with medical ethics has to be in line with behaving morally in general. If an action claims to be in line with medical ethics and yet violates general morality, the action is immoral. So in claiming that medicalisation of capital punishment is against medical ethics, it is not necessarily wrong. The medical associations have to go further to show that it is morally wrong to execute people. This conflicts with their professed agnosticism about the morality of capital punishment.

AGNOSTICISM

The medical associations would like not to be involved in the discussion of whether capital punishment is morally wrong or right. I argue that if capital punishment is not wrong, then what reason do they have to suggest that medicalisation is wrong? What is the morally significant difference between medical involvement and medicalisation? The medical associations have to address the morality of capital punishment. Further, there are other instances where the medical associations approve the medicalisation of certain activities. Abortion is such an example. It is true that medical associations have not decided the morality of abortion. But all the same they have maintained the view that doctors should be guided by their consciences when they are approached to do abortions. Such a decision seems to be based on the unstated argument that it would be wrong to refuse women abortions if they have the right to them. Now, if foetuses are human beings, and there are reasons for allowing women to kill them with the help of doctors, by the same argument, it may be wrong to refuse governments medical executions if certain crimes make prisoners the type of human beings that they have the right to kill.

There are other instances where doctors appear to be involved in activities that are apparently contrary to or could lead to situations that call for activities that are contrary to the preservation of human life. Military doctors are a specific example. Some sports such as boxing do not necessarily promote the health and life of sportsmen, but doctors participate apparently without censure. This is all the more true of doctors who attend unhealthy senior politicians, like Boris Yeltsin. The case of Yeltsin is instructive in that if media reports are correct, he was unwell and yet his doctors kept him up to campaign for elections and to remain in office. Arguably this is not in his interest as a patient, but it could have been in the interest of the Russian people and their access to democracy. Another example is the case of a medical advisor to government. When there is an outbreak of disease like mad cow in the case of Britain, the medical advisor to the government would not necessarily say and do things that are to the interest of particular

patients. He would rather say things that would encompass a larger area of issues such as controlling people not to panic and so on. A physician on the other hand would advice his patients not to eat certain mean products, the thing that the medical advisor would not say. This may show that doctors do not just have the duty to counter every threat to life, or to preserve the lives of their patients by whatever means. Euthanasia is one case where doctors kill their patients in the process of saving them from pain. It shows that saving life is not the sole intention of medicine.

CHAPTER 2

ROLE/PROFESSIONAL VERSUS ORDINARY MORALITY

In what follows I claim that role morality in general is not separate from ordinary morality. This also means that the medical role is not independent of other roles. This is because, as I will argue below, following Allan Gewirth, a role is morally justifiable on the basis of whether or not the institution that created the role violates the right to the pursuit of interest and well being of those involved, and whether the role itself does. This means that the morality of the medical role is not independent of the morality of institutions that prevent the violation of moral rights, such as penal institutions.

Role morality is the special application of ordinary morality. For example business and medicine can be shown to be the special applications of ordinary morality, and once we apply Gewirth's Principle of Generic Consistency, we are able to judge how they should be conducted in a morally permissible manner.

ROLE MORALITY

Those opposed to doctors' involvement in capital punishment make two claims. The first is that capital punishment is morally wrong. That is Amnesty International's position. According to this view, since capital punishment is morally wrong, it follows that no one should be involved in the practice, including doctors (Amnesty International, *Act 50,*1991). I will examine this claim later in Chapter Four and argue that even if capital punishment is wrong, it may well be better for doctors to be involved than not. This is because medical non-involvement can make the plight of condemned prisoners worse.

The second claim made by the British Medical Association, World Medical Association, Amnesty International and others is that irrespective of the morality of capital punishment, doctors should not be involved in the practice because it is directly opposed to the aims of medicine (The American College of Physicians et. al., 1994:13, 37; British Medical Association, 1992). In short, the role of a doctor generates a special morality that excludes involvement in capital punishment. This position implies that professional morality can generate obligations of its own. Thus, the medical profession generates rights and responsibilities that are different from those of ordinary people and other professionals, for example, teachers. I disagree with this and argue that professional morality does not generate obligations that are independent of ordinary morality. Rather, professions generate special obligations that are in accordance with ordinary moral principles.

There is a difference between saying that roles determine what one does and that

professional roles generate their own moral rights and duties that are separate from ordinary morality. The argument that professions generate their own morality implies that there are certain things that professionals can do without moral problems, which ordinarily would be morally unacceptable for other people to do. And there are things that professionals may not fail to do without moral problems whereas other people may escape moral censure. In the case of doctors and capital punishment it means doctors are not allowed certain types of participation (medicalisation) but other people are.

The idea that professionals have a special morality issuing from their role may imply that they do not have other moral responsibilities, which are as important as those that arise from the profession. For example, the medical duties of a doctor might be thought to be more important than the duty to promote justice. Thus the duty of a doctor to ensure equitable provision of health in general may be thought to be less pressing than the duty of the doctor to immunise children against polio. A role may be thought to insulate its holder from other moral responsibilities such that once the person is concerned with carrying out the duties of a particular role; they do not have any other duties at the same time. I do not agree with this view. While a role sometimes determines what one should do morally, there are many roles that people play at the same time. It is when the agent plays all these roles in a balanced manner that they are able to lead a moral life.

In this chapter I will argue in agreement with Gewirth, who says that there is no separation between ordinary and professional or role morality. I will base my arguments on his idea of Generic Principle of Consistency. According to him the basis of ethics is the principle of generic consistency according to which all people equally have the right to autonomy and well being. Whatever action violates this is morally wrong. I will take the example of business and argue that it does not offer a separate morality from ordinary morality. I also apply the Gewirthean theory to medicine arguing that for medicine to be morally right, it has to conform to the Principle of Generic Consistency. To do this I start by looking at what a role involves.

ROLES

A role is a place, position or in Bradlean terminology, a "station" (Bradley, 1951) in a web, a hierarchy or series of relationships, in our context, involving moral agents. It is "a nameable position within a social network" (André, 1991:73). An agent is usually the holder of a multiplicity of roles, and these arise from social organisation. A hierarchicalised society will have roles that conform to that hierarchy and the roles will usually have different duties and rights determined by one's position in the hierarchy. In the present day, we have specialised roles arising from social organisation and needs—medicine, law, and politics—and those arising from socio-cultural beliefs and biology—family, parent, and friend. All these give rise to different forms of responsibility. The roles are public and private. Some have elements of both (Jones, 1984:603).

As human beings, interactions amongst us involve role-playing vis-à-vis one another. Roles range from parent, teacher to doctor. The fact of being a human being carries with it rights and duties that are played out in different ways under different conditions. A stranger does not have the same rights and duties in relation to me and I to

them as somebody who is not a stranger to me. A stranger to me has the right and imposes a duty not to be treated like a stranger by his friend. A parent also has the right not to be treated just like a friend by his child at least in certain morally important ways. For example a parent has the right to decide what should happen to their child in serious matters, such as whether they should continue receiving life-sustaining treatment when they are seriously ill, whereas a friend does not normally have such a right. The same is true of duties arising therefrom. On the other hand we have political roles. The role of Prime minister determines to some extent what particular Prime ministers do. They may authorise soldiers' bombardment of a certain position, or impose economic sanctions on another country resulting hardship for its citizens.

A role, as André points out, has moral weight. That means different roles have moral value according to their relative importance in society. The relationships between roles and their relative moral weight differ from each other and from time to time. Role holders "are expected to act, and perhaps feel, in certain ways. Deviations generate surprise, uneasiness, disappointment, or disapproval." (1991:73) The Bradlean view of role morality is that an individual behaves morally by carrying out the duties of their role. This according to Candlish means that:

> I accomplish self-realisation by taking my place as one of the organs of the total moral organism and doing the duties associated with the station I occupy. This amounts to self-realisation because, as Bradley argues ... the self apart from its place in society is a mere nothing—indeed, the service of the community simply *is* the establishment of one's individuality—and it is self-realisation for the total organism as well because the good will, which is its life, is concretised in all its individual manifestations and is one and the same in each case (Candlish, 1978:157).

This points to two important things. The first is that roles are morally important. The second is that playing roles is part of the human development to such an extent that one may not develop morally entirely outside the context of role performance.

PROFESSIONAL MORALITY IS THE APPLICATION OF ORDINARY MORAL PRINCIPLES IN SPECIAL SITUATIONS

Having said that roles can be a guide to moral life and that they can dictate what one does, do they give rise to special morality that is separate from ordinary morality? Is professional morality different from ordinary morality? In performing their different roles, human beings usually engage in morally problematic behaviour.[5] The question that arises then is how roles fit into morality. Is there a distinction between role morality—specifically the branch of it called professional morality—and ordinary

[5] André considers that roles may demand that we treat people differently. For example, the way people treat their children is different from the way they do others'. This seems to contradict the principle that people should be treated equally. Roles, she points out, "seem to 'switch off' ordinary moral constraints, requiring us to do things that would otherwise be wrong, like helping a guilty client go free. In Richard Wasserstrom's words, a role seems to constitute 'a sufficient reason for doing or not doing something that would otherwise be …morally wrong."
André, 1991:73).

morality? Is role morality simply a branch of ordinary morality? Or, is all morality role morality? Some philosophers have argued that morality is about the performance of one's role in society and nothing more (Bradley, 1951). Others have argued that there is a difference between role morality, especially professional morality, and ordinary morality (Freedman, 1980; Hoffman, 1975; Williams, 1978, 55-73; Carr, 1988). And yet others have argued that there is only one morality and the moral assessment of professional behaviour is nothing but the application of ordinary moral principles in special situations.[6]

In this section I argue that professions do not have their own peculiar moralities separate from ordinary morality. This is because the basic principle of morality is applicable to both individuals in their workaday interactions and in their professional capacities. I also suggest that once we accept the Gewirthean idea of Generic Principle of Consistency (GPC), we can go on to argue in agreement with André that role morality is a complex instance of ordinary morality because one has a reason in ordinary morality to act according to their role.

Professions are a result of social organisation in response to certain needs. This organisation has a moral basis and implications. It is my contention that professions are a pragmatic response to social and individual needs. Society realises that some members need to be controlled in certain ways such that they would not be disturbed in pursuing their legitimate interests whilst being stopped from disturbing others to do the same. This gives rise to legal control and enforcement; hence, the laws and police. Laws become complicated as different situations call for different legal enforcement standards and expectations. This gives rise to the legal profession—law courses and teachers, law making, legal theory and all related matters. Professions are society's specialisation of roles arising from social and individual needs. It is a specialisation in that roles call for the performance of specific duties with rights: duties which other members of society do not need to perform in the ordinary course of events, and rights they do not need to have in order to act morally. André (1991:74) captures this well when she says that:

> a professional and a non-professional are never in the same circumstances, because morally relevant circumstances include a description of the agent: her abilities, promises she has made, expectations which exist about her, and so on. *Every* context, in the professions and outside them, contains moral factors which must 'be weighted more heavily than they would be against other principles in other contexts.' That does not distinguish some professions from others.

Roles have to be taken into account when deciding the morality of an action. If we take an example of a room with many people, one of who suddenly collapsed, we would find that though in the same room, not all of them are responsible for the resuscitation of the collapsed one to the same extent. The owner of the room may have more responsibility, for example. If there were two medical doctors among them, probably they would have more morally important responsibilities toward the patient. Not necessarily the same responsibilities, however. One might have more responsibility in

[6] (Gewirth, 1986:282-300; Gillespie, 1988; Luban, 1988). André, 1991:75, holds that "role morality is not opposed to ordinary morality, but one manifestation of it." Andrew Belsey (1978:115) expressed the same idea when he said, "This is to ask of the scientist no more than of the normal human being; that he estimate likely outcomes of various alternative courses of action before initiating them. To be required to make such estimates is part of what is involved in being human, and I trust that no scientist will claim that there is an internal scientific morality that over-rides normal responsibilities and obligations."

resuscitation because, for example, he specialises in treating collapsed patients. If the two were similarly specialised, the one nearest to the collapsed person might have more immediate responsibility. And so on.

The Hippocratic Oath has a special bearing on doctors' responsibilities. André points out some moral considerations are overridden by the oath whereas others are not. Even those not normally overridden may be, depending on the situation. What is of great importance is that adherence to the oath is itself on the basis of either established or presumed moral principle. Otherwise it would not make sense to say that there is something wrong with violating the oath. One of the reasons for doctors not to violate the Hippocratic Oath is that they have taken it, and it is wrong for someone to go back on their word.

It seems to be reasonable to organise society into different roles because different roles (professions) help society and individual members to regulate the pursuit of each individual's autonomy and well being along side the need to balance that with other's autonomy and well being that may be harmed by the individual. Social organisation gives rise to certain duties, rights and freedoms, which the individual has to enjoy in order to realise self-fulfilment and well being.

I follow Gewirth in holding that ethics is firstly about moral rights and secondly about the freedom to enjoy those rights and not to be impeded when pursuing them. One may ask how we come to have rights. According to Gewirth, people generally want to pursue what is in their interest and well being. This in itself does not imply that they should have the right to do so. But once we consider that people can pursue their interest and well being without harming others, there does not seem to be a reason for stopping them, as long as they do not harm anybody. They have the *freedom* to pursue their interest and wellbeing. Freedom is the ability or capacity to control one's behaviour autonomously with the knowledge and understanding of relevant conditions and circumstances. Wellbeing is the state whereby the agent is able to have the necessary conditions for acting successfully in pursuit of their fulfilment and purposes. Every individual human being has the right, equally with any other individual, to pursue their freedom and well being which we may call "essential goods". This is what Gewirth (1986:288) calls the Principle of Generic Consistency (PGC). Now if all persons equally have the right to the pursuit of their well being and freedom, it means any impediment of such pursuit is morally wrong. It also means that the right to well being and freedom gives rise to the duty not to interfere in others' pursuit of these essential goods.

The pursuit of such essential goods is normally inviolate. It is one's moral right to be allowed and even assisted in, or not to be impeded in pursuing their essential goods. This means only special conditions should allow their infringement or violation.[7] For example, to deprive someone of life is normally to violate his or her moral right to life. There must be a very good reason should that happen. One such reason is self-defence in which case the aggressor's right to life is infringed to stop another violation—the life they are threatening and their victim's right not to suffer unprovoked attack. In this case two important rights are evidently in conflict, and the infringement is allowed because of the seriousness of the threat. A person would not be executed for stealing chocolate

[7] Gewirth (1986: 285) distinguishes between violation of a right and the impingement of one. The former is morally wrong whilst the latter is, or may not be wrong

for example. This is because of the difference in importance between the two rights involved—property and life.

This theory has implications for role morality and its alleged separation from ordinary morality. If we accept that people have moral rights, it seems to be reasonable that in pursuit of those rights people individually and socially may engage in different strategies. The most obvious one and yet the one with the greatest moral implications is the creation of institutions. The first observation about an institution is that it has the potential of promoting autonomy and well being for a lot of people whilst threatening the erosion, impingement and, or violation of others' autonomy and well being at the same time. Morality is about protecting the legitimate pursuit of autonomy and well being of human beings and the balance of that against violating others' pursuit of their own by the individual subject. Role morality is about the protection of the legitimate pursuit of individual's and social groups' or society's autonomy and well being through specialist or professional efforts, and its balance against violating some individuals', social groups' and societies' autonomy and well being. The institution also is formed to enhance its members' interests or essential goods, and it follows that the institution should not be impeded in pursuing its members' legitimate interests or essential goods. After all, if an individual has the right to pursue essential goods, he has the right to co-operate with others in his pursuit of the essential goods. In pursuing their interests or essential goods, individuals have the duty not to violate others' rights to the pursuit of their own interests or essential goods.

The main problem with this view is that whilst it seems to be clear that rights to life, shelter and food are fundamental, it is not easy to determine their place in the hierarchy of importance. For example, the right to life is fundamental to such an extent that it cannot be violated without affecting the claim to others. If one has the right to life, does it come before respecting the subject's wish to die when faced with terminal illness? Even applying the standard, is it in accordance with the subject's interest to die or to continue living an almost vegetative life? If there is a choice between having the subject's will violated and respecting the right to life, which one is to prevail? Whilst this is indeed a problem for our view of morality, it is not peculiar. Every moral philosophical view has to deal with this problem, and their solutions do not appear to be any better than what would be offered by our view.

If we take role morality we find that actions can be justified at three levels:

i) institutional rights.
ii) justification of institutions.
iii) justified institutional infringement of rights.[8]

First, concerning institutional rights, we find that institutions have rules which give rise to roles and rights within those roles. For example the family institution gives rights

[8] This is similar to Luban's (1988:xxi) observation who holds that "appeals to role morality follows a standard four-step pattern, which I call 'the Fourfold Root of Sufficient Reasoning': one justifies a morally disquieting action by appealing to a role-related obligation; one justifies this role-related obligation by showing that it is necessary to the role; one justifies the role by pointing to the institutional context (such as the adversary system) that gives rise to it; and finally, one demonstrates that the institution is a morally worthy one. The weaker the argument is at any of these steps, the weaker the appeal to role morality will be. The Fourfold Root of Sufficient Reasoning amounts to nothing less than the deep structure of role morality." The Gewirthean view however seeks to justify even particular actions on the basis of whether they contradict the PGC even within the justified institutions etc.

and roles of motherhood—nursing children, education etc. The economic institution establishes rights and roles of commerce—I have a right to take vegetables out of a grocer's shop when I have paid the correct amount and the grocer has to let me have them etc. This means rights can be conferred by fact of an institution. That is, in institution A the rule is R. It is justified in that context when I follow R in A.[9]

If there are indeed different moralities of political office-holding, medicine, business and law separate from ordinary morality, then the professions have rules which create roles with related rights. Claiming rights consistent with the rules justifies actions within those professional institutions. Justification of actions merely at the institutional rights level may not be morally adequate because the institutions themselves may be morally unjustifiable. Examples of such institutions are slavery, Suttee, and the Inquisition. The same is true of professions. Consider the roles of the Inquisitor, the expert appraiser of slaves, the guru director of suttee etc. Because they are roles or professions of morally unjustified institutions they are not morally legitimate professions. So the fact that a right derives from the rules and roles of some institution or profession is not of itself sufficient to justify the right; it is therefore not sufficient to justify an institutional or professional right's infringement of some moral right.

Secondly, for an institution to justify a right that it confers, the institution itself must be justified. This justification is by means of conformity to the three conditions stated above. For a right to be conferred by an institution, that institution has to promote moral rights, freedom and well being. This happens procedurally and instrumentally. That is, the procedure of establishing such an institution must satisfy the three conditions. Those involved for example must consent to its existence, rules and roles. An example here is the legal institution. The instrumental justification at this level is that a right is held to be justified because it derives not just from the rules of some institution but rather from the rules of a morally justified institution, and therefore a certain institution, rule or role, is a means by which people can pursue their interest and well being.

Thirdly, institutions that are morally justified make rules that create roles conferring rights. Such institutions can sometimes justifiably infringe moral rights. This happens when there is a conflict of moral rights and their hierarchical arrangement is considered when such action is taken. For example, assuming that the legal institution is morally sound[10], a murder suspect is at least potentially a right-of-life-violator. The rules (law) allow the police to arrest and interrogate, hand him to the Prosecution Service when there is evidence, which will let the accused answer in a trial. Once shown to be guilty the murderer will have his freedom further infringed. This infringement of freedom begins at arrest[11] and it is considered that it is in a way better to infringe this right

[9] The question may arise as to what justifies the rule. A justified institution creates rules in order to carry out its duties so that the rule is justified by the institution's need for means of carrying out its duties.

[10] The moral soundness of the legal system is the basis on which a criminal is called to account for his criminal actions. This means, the violation of a morally sound rule without moral justification calls for moral censure.

[11] There could be an objection to the effect that arrest may not be a genuine infringement of freedom, because it may be what everyone fully accepts as legitimate when there is evidence of one having committed a crime. It could be legitimate, but that does not mean the suspect does not have the right to freedom. Reference is made to the violation versus infringement distinction above according to which Gewirth holds that violation of a right is something morally wrong like murder. Murder supposes the agent does not have any excusing or justifying reason for their act of murder. That is different from an infringement, which is a justified "violation" of a right. The right is acknowledged, but there is reason for overriding it. A murderer's right to

because potentially (at least legally until proven guilty), the suspect has violated a more serious moral right—right to life.

As stated above, there are three levels of action justification. That is, justification of: institutions, institutional rights and institutional infringements of rights. Those who think professional ethics are autonomous see the third level, (justification of institutional infringements of rights) as based on the first level (institutional rights). For them the institution of medicine justifies the activity of the doctor so that all he has to do is appeal to the belonging to the privileged profession (Freedman, 1980). My contention is that the justification of institutional violation of rights is required to complete the moral justification of particular actions.[12] The three conditions are applicable either directly or indirectly, depending on whether the act assessed is about institutional rights or not.

To say that human beings have moral rights issuing from their pursuit of essential goods and therefore the morality of institutions and roles is determined by the extent to which their pursuit of these goods are interfered with, violated or infringed upon is a general position. It may sound reasonable, but does it apply to concrete situations? To put it to the test we shall attempt applying it to business and medicine.

BUSINESS MORALITY IS NOT SEPARATE FROM ORDINARY MORALITY

The view I have advanced above is that morality is about the respect or otherwise of one's right to pursue their essential goods. Morality is an attempt to strike a balance between such pursuit and the possible violation of others' rights to do the same. The implication of such a view for roles is that a role is right or wrong depending on whether it is created by an institution which respects or meets the conditions or people's interest and their non-violation and whether the role itself violates others' right to pursue their own interests. This means that what acting individually and acting according to a professional role have in common is that each would be assessed morally by asking whether it violates others' right to pursue their own interests. In this section I argue that business is morally permissible. It is legitimated by a) its pursuit of the entrepreneur's autonomy and well being and b) non-violation of others' pursuit of their own essential goods (autonomy and well being). The standard is the same for business and individuals. This gets rid of the ordinary versus business morality distinction advanced by separatists.

One of the reasons for supposing a separation between business and ordinary morality is that "commerce is satanic, because it is the basest and vilest form of egoism." [13] Thus, the question arises; can one behave morally in the ordinary sense and

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life is infringed when he is duly executed for the act. At least those for execution would say that it is necessary that the murderer be regrettably executed because not to do so would be a moral wrong worse than the infringement of his right to life. Like wise, the suspect does not lose their right to freedom when they are arrested. This is what Phillip Montague (1988:349) calls "the moral residue argument" according to which when good moral reasons are overridden by weightier ones they do not disappear but are residual.

[12] The issue concerning medicine and other professions is not that they are not justified. What we have is that medicine is justified together with the army, law and others, but then the justified institutions and professions can conflict with each other. That is a different level of the debate.

[13] This view is attributed to Baudelaire by Tibor R. Machan and Douglas J. Uyl (1987:107).

engage in business? If one cannot behave morally in the sense of ordinary morality while engaging in business, then probably there is a difference between behaving morally in the sense of ordinary morality and behaving morally in the business sense. I argue that there is no necessary tension between business and ordinary moral behaviour. One can be engaged in business and still be morally upright.

One way of examining the issue of business morality and its relationship to ordinary morality is to enquire what business morality is. This is not an easy task as definitions are limiting and almost always result in undesirable implications. But we can take a cue from the suggestion that moral judgements about the economy include questions about the just distribution of scarce resources—public finance, efficient funding of government through taxes, right and just ways of taxation, etc.[14] Likewise, business morality should be about the just way of doing business. This is suggested by Machan and Uyl who think that ethical theories are an attempt at answering the question, 'how ought I to conduct myself?' They point out that "since ethics or morality aims at identifying what human beings ought to or ought not to do, and since ought ordinarily implies can, ethics or morality deals with matters of goodness which are in our power to choose to pursue" (Machan & Uyl, 1987:108)[15].

How has business come to be a familiar part of life? If we accept that human beings have rights, including the fundamental one of the pursuit of one's essential needs (autonomy and well being), we find that business is acceptable. Engaging in business, the individual has the duty not to violate other people's rights to pursue their own essential needs. So from the individual's right to pursue essential needs (autonomy and well being) and duty to respect others' arise the business' right to exist and its duty to respect people other than its owner, by not violating their right to pursue their own interest. We can say that if a business is set up to undermine other people's autonomy and well being it is a morally bad business and should not be allowed to operate. If however a business is formed to pursue the legitimate rights of its owner, it is a morally permissible endeavour. It would appear to be absurd to condemn a person for violating others' pursuit of their own interests when the violator acted as an individual and not to condemn him when the person does the same thing through his business venture. But then is it the same thing to say that a business violates rights as to say an individual does? Without people a business is nothing that can be said to violate rights. But that is not morally significant. The morally significant thing is that if an entity is able to act in a way that could violate people's rights, the entity must not be allowed to do that unless there is an excusing reason. In this sense both an individual and a business are similar. The standard for prohibiting certain behaviour is applicable to both the individual and a business. Just as it would be unreasonable in my view, to allow an individual the freedom to pursue their autonomy and well being as an individual but not as a member of an organised effort, it would be equally unreasonable to say that the individual has responsibilities whilst they pursue their interest on their own but not when they do so as

[14] This kind of argument is advanced by Ronald H. Barback (1954:30-47). William Vickrey (1953:150) argues that "no morally responsible economist can get far, and no one who wants to make policy recommendations concerning economic matters can get anywhere, without at least implicitly calling upon some set of ultimate values. For some limited fields of economic decision, the values may necessarily seem to be so clear and universally assumed that nearly everyone would agree that it is better for individuals to be well fed and clothed than to be hungry and naked."

[15] Some important authors in the area are De George (1990); Davies (1997) and Boatright (2000).

part of an organised group or through a business venture.[16] This is not to deny that there are legal rights and duties that apply to individuals but not to businesses and to businesses but not to individuals. For example individuals may not be allowed to buy some goods from wholesalers when businesses are allowed to, and requirements that have to be met by businesses may be different from those imposed on an individual.

It is quite clear that the law may allow both individuals and businesses to engage in activities that could be detrimental to others' pursuit of their own autonomy and well being. Examples in history are slave laws, apartheid in South Africa and religious persecution practices of the past. This shows how morality is actually different from legality and how the latter does sometimes violate the former. In the situations where immoral practices and laws are prevalent, we would say that the individuals and businesses are immoral if they exploit the same immoral laws and practices. An individual exploiting the slave laws to gain something would be engaged in moral wrong doing just like a business that exploits the slaves or related services.

Sometimes it is suggested that business aims at profit making and that comes before everything else that a businessperson does. If some other goal were adopted, such as pursuing the best moral consequences, the business would not survive, or it would cease to be business (Carr, 1988). It is also argued that if people want to live a moral life, they cannot be business people, since business involves doing things that ordinarily would be immoral if not done in business. The problem with such a view is that it does not seem to be based on a sound understanding of what business ought to be rather than what people have made of business. As Tom Sorell (2000:75) puts it, "Moral precepts do not fail to apply and to have overriding authority over the people who are in business, even if in order to follow them one has to invent a new style of business." To suggest that business contradicts morality is tantamount to saying that not all people can pursue their own interests without violating others' rights to pursue their own. This is evidently wrong. The assumption of moral sanction relating to people's pursuit of their own interests supposes it can be done without the violation of others' rights.

The profit motivation for business is not in principle contrary to morality. Even individuals in their everyday interactions do things, which in total can be to their own advantage and profit rather than that of others. This includes things that are not only to the individual's advantage but also directly to the disadvantage of others. For example, in competitions not everybody is a winner, and some losers might be in more need of the prize than the winners. But nobody would say that the individual who won did something inconsistent with others' interest if that means an immoral thing—violating their right to pursue their own interest. Business deals involve other people's interests not necessarily being enhanced. But one would say that a certain amount of conflict with other's interests is inevitable and necessary if a business is to survive. On the other hand, it is true that business is not the sole source of essential goods; otherwise the moral status of trade would be different. For example, a business is able to turn away anybody who does not have money without giving them the goods. The moral status of

[16] An organised group that becomes so powerful that it threatens other legitimate interests would be behaving impermissibly if it took advantage of its awesome power. Consider a situation whereby one of the two parties in a relationship has more power, knowledge or some other advantage over the other. Exploiting opportunities offered by that advantage might cause moral problems. An example is the relationship between human beings and other animals. The fact that humans can dominate other species does not justify certain ways of treating animals.

a business would change if oxygen could all be captured (without leaving any in the atmosphere) and businesses sold it. Those without money would need the oxygen. A trade in oxygen would be immoral if it means those without money would die for lack of oxygen. Anybody going into the oxygen business would have to be warned of the possible collapse of the business because their commodity is the type that is essential for the existence of others and they could not go without it. If a business for oxygen selling were licensed, it would be a morally wrong law if it could be allowed to turn away those without money for the oxygen.[17]

A business may do certain things to attract customers and to ensure that they prefer it to its competitors. There are ways in which this can be done without engaging in immoral behaviour. The business for example could offer what others do not, or sell goods at cheaper rates. It would be wrong for a business to start a smear campaign against its competitors. The same applies to an individual. On applying for a job he tells his prospective employers what he is capable of doing, his talents and strengths. He does not seek to show how inadequate other applicants are. Just as the individual would not be allowed to kill his competitor who threatens to beat him to the job, a business would be behaving immorally if it did something to undermine its competitors—for example spread damaging untrue allegations about them or threaten, even kill, its important employees so that they stop working hard for the competing business. Things like industrial espionage are not morally acceptable: when pursued, they destroy other's chances of attaining their own autonomy and well being. [18]

In short, business does not insulate its practitioners from moral responsibility. A businessperson has other moral responsibilities besides those of his profession. If a businessperson has the moral right to run his business and enjoy the profits of this business, it is not the only moral responsibility he has. It is his moral duty as well that in business he does not tell lies, for example claiming certain goods have benefits which they do not have, or selling harmful goods which are very profitable. This is what makes businesses for selling drugs such as ecstasy morally wrong. What makes them wrong is not that the owners make money, but that the goods traded violate or interfere with others' right to pursue their own autonomy and well being. If drugs cause death and disease, they are not for the interest and well being of the users.[19]

Now let us take some moral theories and see how they may be applied to business morality. A utilitarian would answer the question, "how ought I to do business?" by pointing out that it is by business people not lying, killing and so on that everyone—the business persons and customers—will benefit. There would be mutual trust and confidence. The customers' confidence and trust would be based on the experience of business—if all knew that a business person would not cheat for example, that would give them confidence in business. Advertising standards would not need to be that rigorous (if any would be needed at all since information provided in advertisements

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[17] It might be all right for businesses to turn away people, so long as there was a non-business source for the same goods.

[18] Carr (1988) would not agree. He would say that espionage is part of the game played in business.

[19] The question that may arise here is whether the exercise of autonomy necessarily promotes one's interest and well being, and if it does not, whether it is immoral. For example, smokers do not necessarily have their autonomy violated by being sold cigarettes when they freely chose to smoke. Is it morally right to sell them? If being freely engaged in something that risks the life of an agent unnecessarily is wrong, may be the sale of cigarettes would be wrong for similar reasons.

would be enough to convince the customer to buy services or goods without misleading them). If business and commerce were, on the contrary, like a state of nature situation, nobody would trust business. This would have negative utility, as the businessperson would suffer from the trickery of the customer on the one hand and that of other competitor businesses on the other. The consumer would also suffer from unfair competition for good bargains by fellow consumers or from exploitation by business.[20]

Carr's view of business seems to be self-defeating in that it crumbles under theoretical scrutiny. For example, he holds that business people usually act according to different moralities. They have to act as business people and have disregard for ordinary morality at some stage—cheat, lie, be engaged in industrial espionage and so on, and then act in other contexts as non-business persons where they respect ordinary moral principles. This results in moral tension for the businessperson. If we use utilitarian considerations to assess this view of business, we would say that it is morally wrong to engage in that of type of business. As Sorell (2000:76) puts it, "Utilitarianism represents as morally obligatory whatever practicable policy or action tends to increase the most the welfare of sentient beings. The theory lends itself to arguments that say that the split life of the Carr-approved businessman is psychologically harmful if generalised and therefore better avoided on moral grounds." If engaging in business means having two moralities—business and personal, there would be a problem of disutility as the agent is torn apart by his moralities when they conflict.

One does not have to have utilitarian justification for business activities. Somebody can say that rather than behaving morally in business because it pays, people can behave morally because moral behaviour is motivated by the will to do right simply because it is morally right. Sorell gives the example of a company that is founded on moral principles. The company has good policies for everybody—workers, clients and management.[21] We also have other moral obligations for business that are widely accepted such as protection of employees against injury and the truthful declaration of profits to shareholders. This is justifiable on other grounds besides utility, giving credence to other moral views such as virtue theory. This can be gleaned from Sorell who says that:

> if one's identification with both one's job and one's home-life is significant, then it is plausible to hold that following rules in one sphere that one cannot follow in the other is not

[20] Norman E. Bowie: (1997: 119-120) says, "there are many arguments that can be used to show that ethics can contribute to profits rather than diminish them. ... Indeed," he goes on, "an ethicist can show that in certain circumstances ethical conduct provides a competitive advantage. In this way ethics becomes part of the strategy." He goes on to show that ethical behaviour reduces transaction costs, solves agency problems and establishes trust among stakeholders.

[21] "The motivation for these policies" he argues, "was not the enlightened self-interest of the corporate social responsibility theorists, but something more elevated. The owner had a certain vision of how a fair working and shopping environment could be engineered, and he was in a position to realise this vision as a sort of elaborate social and business experiment. He did not need to find business reasons for his vision: the business was his to develop as he liked. Few firms that might follow the example of John Lewis are led by people as unanswerable to others as the founder of the Partnership. So one would not necessarily condemn these companies for refusing to go as far as John Lewis did, even if they agreed that the policies just outlined were admirable. The idea that the John Lewis policies are supererogatory is intelligible, then, however much they are held up as an example in business ethics. John Lewis Constitution calls for a sort of treatment of employees and consumers that is right in the way that generous actions are, but other firms may reasonably refuse to follow this example on the grounds that for them John Lewis policies would be too costly: major shareholders might object; top management might feel hemmed in by fixed use for at least some of the firm's profit, and so on." (Sorell, 2000:81-82).

> just a psychological but a moral problem, since one cannot occupy both spheres with integrity, and integrity may be part of living life honestly or flourishingly—where both honesty and flourishing have moral content. The fact that it may be possible for business people to keep the two spheres separate in the sense that activity in one is kept out of sight of the other sphere does not mean that they *are* separate or that one sphere does not have consequences with moral significance for the other (Sorell, 2000:75-76).

A Kantian argument would probably suggest no separation between ordinary and business morality. The important issues that would arise for a Kantian are to ask whether one can do business justly and whether people can be treated with dignity in business transactions. Part of justice is for an agent to do their duty. That most probably would involve respecting persons as agents with dignity rather than price. Kantian business would exclude treating people merely as means and include treating them as ends in themselves. Cheating is an example of not according an agent dignity befitting a rational being. This confirms what Luijk (1995:209) means when he says that whether or not there is justice (just distribution of economic goods) is a morally important question. He goes on:

> to subject market transactions to a moral judgement is not an intrusion in an autonomous and self-supporting real of action. It is the normal exercise of critical reason. Much more interesting than the normative question *why* we are entitled to value economic actions in terms of justice is the empirical question *where* our longing for justice comes from, and the normative one about *what* is the proper content of actions judged to be just.

According to Machan and Uyl (1987:116) "to profit from an activity is to gain more from it than one lost in it." This can be done without insulting the dignity of an agent. This is because when two people are facing each other in a business transaction both are aiming at profiting. "This objective can be reached under the condition that roughly equal values are exchanged and that, on both sides, profits are roughly equal. So equality serves as the basic principle of a *justice of exchange*, that itself is a subset of distributive justice" (Machan and Uyl, 1987:212). Bowie (1997:119-120) has also advanced an argument that does not mean people in business should be moral since it pays, but rather because it is the *morally right* thing to do. Lunati (1997) has characterised business ethics in terms of the contrast between what she calls *homo economicus* and *homo ethicus.* Her characterisation is summarised in tables 1-3 below.

Table 1. Economic vs. Ethical Behaviour

Homo Economicus	*Homo Ethicus*
At the centre of neoclassical economic theory human beings are utilitarian, hedonistic, self-centred, rationalist and individualist. The person is selfish, a maximiser, acts independently, isolated without cooperation, no sense of society/community, appears to be immoral/unethical, antisocial. Often cheats, lies, steals, misleads, disguises, obfuscates, feigns, distorts and confuses. He is greedy and untrustworthy, untrusting and a free-rider. Punishment and incentives motivate him	Altruistic, cooperative, honest, truthful, trusty & trustworthy, believes in obligations to others and honouring them, sense of duty, rational altruist, observes friendship, love, dignity, autonomy, respect for self and others, believes in social justice, fairness and equity. Believes in equality of humans. Opposite of homo economicus

Table 2. Neo-classical vs. Ethical Business

Neo-classical Business	*Ethical Business*
Just profit motivated, no other social responsibility, obligated to shareholders only. Fiercely competitive, aggressive, immoral means employed to gain, maintain and expand market share, elimination of competitors intended. Can scheme with anyone to exploit any other. Its workers are not committed; have to be forced by contracts and incentives. They are untrustworthy and need supervision	Profit motivated but not the sole purpose. Has other social responsibilities besides profit to shareholders etc., has responsibilities for employees, consumers, suppliers, creditors and competitors who they do not seek to crush. Competition is for mutual improvement. Co-operative with others. Does not collude against anybody. No need for supervisors as police but as mentors of less experienced stuff. Employees motivated as they share objectives with the business. Opposite of neo-classical business

Table 3. Neo-classical vs. Ethical Market

Neoclassical Market	*Ethical Market*
Neutral ethically, politically, socially, culturally. Property rights important, and free trade with minimum government interference.	Morally, socially and politically sensitive. Socially responsible. Call for state intervention for the protection of consumers against possible exploitation etc., for the promotion of the general good and welfare. For the general health of economy and individual wealth. Opposite of neoclassical.

Lunati (1997:143) summarises:

> moral values and norms such as altruism, cooperation, solidarity, trust, honesty, truth-telling, obligation, duty, commitment, restraint, no-aggression, social justice, fairness, equity: these are the main values of ethical man, of an ethical firm and ethical markets. And only through their existence, survival and evolution can the 'bad and barbarian' society ultimately be displaced, and a 'good and civilized society' prosper in its place.

This characterisation of ethical business, if correct, helps us understand its moral importance. Not many would deny that *homo ethicus* displays morally acceptable behaviour in the ordinary sense. *Homo economicus* on the other hand, is associated with immoral behaviour in the ordinary sense.

The view I am advancing rules out the separation thesis—the view that business morality is separate from ordinary morality. The argument is that morality is about human rights among which the fundamental is the right to autonomy and well being. Business is a way of the businessperson's attempt to pursue his interest. Whatever moral responsibility or morality applies to the individual as an individual applies to them ***as an individual who is engaging in business.*** There is no separation between being an autonomy and well being seeker as a person, and an autonomy and well being seeker as a businessperson. The two are just different ways in which the person can pursue their autonomy and well being. It is beneficial to behave morally, and so there is at least a utilitarian argument to the effect that business must be moral. From a Kantian perspective too, business is not a separate sphere, morally.

MEDICAL VERSUS ORDINARY MORALITY

Is there a separation between doctors' morals and ordinary morality? Is it right that medical professionals should claim special dispensation to do what other people are not normally permitted to do, or to omit to do what non-doctors are called upon to do? In this section I argue that, as in the case of business morality, medical morality is not, or at least should not be separate from ordinary morality. If it makes sense to hold the view that the basic moral right is the individual's ability to pursue their interest to the extent it does not violate anyone else's right, then medical institutions and medical practice should be viewed in this light. The inevitable conclusion is that there is no separation between ordinary and medical morality. In particular, institutions that are set up for the protection of rights in general should be supported if there is a conflict between them and medical ethics. This is consistent with Gewirth as I am going to show below.

One supporter of the view that medical morality is separate from ordinary morality is Kass. He holds that "the medical profession has its own intrinsic ethic, which a physician true to his calling will not violate, either for love or for money" (Kass, 1996:231f). For Kass, medicine should be considered "not as a mixed marriage between its own value-neutral technique and some extrinsic moral principles, but as an inherently ethical activity, in which technique and conduct are both ordered in relation to an overarching good, the naturally given end of health." This is separate in particular from economic goods, according to Kass:

> to serve the desires of patients as *consumers* should be the task of agents other than doctors, if and when it should be the task of anyone. ... even in its fuller sense, happiness is a false goal for medicine. ... I reject, next, in passing, the claim that the alteration of human nature, or of some human natures, is a proper end for medicine, whether it be a proposal by a psychologist for pills to reduce human "aggressiveness," especially in our political leaders, or the suggestions of some geneticists for eugenic uses of artificial insemination, or the more futuristic and radical visions of man-machine "hybrids," laboratory-grown "optimum babies," and pharmacologically induced "peace of mind" (Kass, 1978:101).

A separation of medical ethics from ordinary morality means that behaving in accordance with one is morally permissible even if it means the violation of the other's principles. The application of Gewirth will show that this position is not sustainable. Let us imagine a situation where there is a special elite force that is used by a (morally legitimate—duly elected and so on) government to suppress, torture and even kill some people who organise poor members of society into economically viable co-operatives that are geared towards improving their lives. The special force's members usually get injured during their routine training, which is very rough and is designed to make them "tough men." On average, let us say, they sustain a few major injuries a week and minor ones are treated every day. In addition, many of the force members suffer psychological traumas as a consequence of training and tasks they get assigned to.

The principles of medical ethics may demand, at least prima facie, that the physicians and psychiatrists attend to these men when they are presented to them for medical treatment. If it is true that medical ethics bars its practitioners from enquiring into the moral behaviour of their patients, it would not be a violation of medical ethics for the doctors to treat the members of the force. This would be so, even if the doctors knew that after recovery, the force members would head directly to the next street, hunting the co-operative organisers. The important question is to ask whether such

medical involvement is morally permissible. Could doctors even be recruited into the force to make them readily available for the service of the force members? If medical ethics were separate from and independent of ordinary morality this question would be nonsensical.

The view represented by Kass has the potential to violate people's rights if the medical profession followed its demands. I agree with Beauchamp and Childress who distinguish between what they call particular moral codes that govern groups—lawyers, nurses, doctors and so on (professional morality) and general moral codes (ordinary morality) that govern whole societies and apply universally.

> The word *morality* often refers to this general code and the practices it spawns. An example of a simple rule in a general code is "whenever you have promised to do something, then you have an obligation to do it." By contrast, a special or professional code specifies action-guides for a particular group, such as physicians or nurses. These action-guides should be justified by reference to more general principles and rules, which may not be explicitly identified in the codes themselves.
>
> Even if general theories or principles were never considered in the drafting of the codes, the directives in the codes can nonetheless be validly criticized or defended by appeal to general principles, as can many policies and regulations that have been formulated to guide professionals. ..
>
> Professional codes are beneficial if they effectively incorporate defensible moral principles and rules in the relationships they govern (Beauchamp & Childress, 1989:11-12).

Following professional codes may mislead the professionals to suppose that they are behaving morally when such codes oversimplify morality. For example, a lawyer may think that following the legal code of ethics is equivalent to morally permissible behaviour for lawyers when in actual fact the code of legal ethics may have moral deficiencies.[22] Medical ethics has a lot to say about nonmalefiscence, benevolence and confidentiality, but very little about human rights and justice. This is due to the fact that professional codes usually have incomplete and unclear moral justification. Government intervention is usually an attempt to remedy this situation, and it is by means of legislation. There are many examples, such as regulations governing experiments with human subjects and licensure for medical practice.

If we look at the imaginary case of the Special Forces above, we find that there is a moral problem. Whilst the concerned doctors may argue that their involvement is purely "professional" in the sense that it is consistent with medical ethics, if it is, there are moral grounds on which they could be criticised if such involvement is in spite of their awareness of what the force members do. On Gewirthean principles, the formation of that force is morally impermissible because they violate the moral rights of the co-operative members. Once we agree that the co-operative organisers are not violating anybody's rights when they help the poor, in fact they are doing the morally right thing—enhancing others' right to pursue their interest and well being without violating others'—and that these poor people are not violating any right when they co-operate

[22] This is what Robert M. Veach (1976:76-77) believes as well. He says, "medical ethics must not be thought of as a special 'professional ethic' at all, but as a specific application of the universal norms of ethical action. ... the professional codes of medical ethics, are actually dangerous diversions which lead professionals to believe that there is a special type of ethics appropriate for their own professional discipline."

with their organisers, then we would agree that the government would have no moral right to create a force to thwart their efforts since such behaviour violates the rights of people to pursue their interests.

All this shows that there is at least an apparent conflict between the co-operative members' right to pursue their interest and the medical doctors' role in the whole affair. I contend that the role of doctors in this case is morally impermissible because it serves an institution that violates people's moral rights. Applying Gewirth, we find that if the government that made the law on which the formation of the special forces is based is morally legitimate, then we have a case of a justified institution creating an unjustifiable institution and roles—torturers and killers (special forces) together with their carers (medical doctors who treat them). It is analogous to a morally legitimate government legalising slavery or the subjugation of women.

The above example of a justifiable institution creating roles that violate people's moral rights also brings out an interesting point, which is important for the debate about the separateness of professional morality from ordinary morality. This is because the above case can be contrasted with institutions that are for the protection of moral rights, like the justice system. Is it morally permissible for medical doctors to disregard the demands of the justice system especially when there is an apparent conflict with medical ethics? Kass would probably answer in the affirmative. The problem is that if doctors disregarded institutions that protect moral rights—claiming to be concerned only with their professional morality—it could result in the violation of people's moral rights.

CHAPTER 3

THE MORALITY OF EUTHANASIA AND ITS IMPLICATIONS FOR THE MEDICALISATION OF CAPITAL PUNISHMENT

The medical associations and the Kass-type argument is that medical doctors have their own peculiar morality that is separate from ordinary morality. I have addressed the issue in the last chapter. They also hold that the medical role should not be involved in killing as medicine is for the preservation of life. In this chapter I argue that the medical role does not only require the preservation of life. I make use of the morality of euthanasia and suggest that medical doctors can justifiably euthanise their patients in some cases, and once this is granted, it shows that saving life is not the only goal of medicine and euthanasia is not against medical ethics. Medical ethics also has something to do with the interest and well being of those concerned. Even if euthanasia is not always morally acceptable, it can be, which would suggest that the preservation of life is not the only requirement of the medical role.

The word "euthanasia" is derived from two Greek words "*eu*" and "*thanatos*". "*Eu*" is a word which means "good," a synonym of "*kalos*". So the word "euthanasia" means "good death." The Greenwich English Dictionary defines euthanasia as "an easy death: a putting to death by painless means" (Patterson, 1990:) "The Concise Oxford Dictionary defines 'euthanasia' as a 'gentle and easy death' and the 'bringing about this, esp. in cases of incurable & painful disease" (Campbell & Collinson, 1988:121). Such definitions do not seem adequate because they include practices that do not normally qualify to be called such. For example, a murderer can kill his victim painlessly and it might be controversial to call what Nazi doctors did euthanasia.[23] To make it more accurate, Philipa Foot insisted that such a killing must be "for the sake of the one to die" (Campbell & Collinson, 1988:121). The idea of a good death, or "dying well" is paramount here:

> It is entirely feasible that ending one's life for oneself might be a way of securing a good death. This involves issues of individual autonomy and human dignity. It involves empathy, responsibility and concern. The ultimate value that may be aimed for by both the person to die and those related to him is happiness. The good death should be such that all those

[23] Jozsef Kovacs: (1991:13), says, "the unacceptable practice in Nazi Germany, where mentally ill patients were killed under the name euthanasia, was not really euthanasia, but simply mass murder, because it was practised in the presumed interest of society and not in the interest of the patient."

> concerned should be happy and satisfied, all things considered (Campbell & Collinson, 1988:116).[24]

From the above we can glean a provisional definition that euthanasia is the killing of a person in a painless way for the good of that person. Voluntary euthanasia is when the person to die wants to die or even asks for it especially when he cannot kill himself. Involuntary euthanasia then would be when the person to die does not want to, but others decide it would be good for him. Non-voluntary euthanasia is the same practice done on someone who is not in a position to ask for death because either he has lost his capacity to consent to being killed or ask for it, or because he never attained that capacity. Examples of the latter are children who are born with serious physical and mental deformities whilst some of the former are adults who are in persistent vegetative states or coma. There is also a difference between passive and active euthanasia. Active euthanasia is when somebody carries out the act of killing the patient whereas passive euthanasia is when treatment is either withdrawn or not given (Evans, 1991:19).

Miller and Brody have advanced an argument in favour of physician-assisted death or euthanasia as a last resort, and they have made use of the idea of professional integrity by which they mean "an approach to integrity understood as a professional virtue of physicians, which is distinct from, but not in conflict with, the virtue of integrity in common morality" (Miller & Brody, 1995:9). According to them integrity involves behaving in accordance with one's values, principles and norms. Professional integrity is behaviour that is consistent with one's profession's values, principles and norms. These are usually internalised by professionals when they undergo training, which is a kind of socialisation. In the case of medicine these values, principles and norms are pursued through its goals which Miller and Brody list as: 1. Healing—cure, repair, restoration and the saving of human life. 2. Promoting health—interventions to prevent disease or injury, the promotion of health enhancing behaviour, vaccinations etc. 3. Helping patients achieve a peaceful and dignified death—coping with terminal illness and palliative care.

These three goals of medicine have to be achieved by the professionals maintaining their dignity and integrity through basic ethical duties of: 1. Competent practice. 2. Avoidance of disproportionate harm to patients in providing medical benefits. 3. Refraining from fraudulent misrepresentation of medical knowledge and skills. 4. Fidelity to the therapeutic relationship with the patient, which means a) not to abuse patient trust and b) not to abandon the patient (Miller & Brody, 1995:11).

There is obviously no argument about the first two goals of medicine since everyone is most likely to agree that healing and promoting health are what medicine is mostly about. One would hope as well that the goal of helping patients achieve a peaceful and dignified death, where death is inevitable, is equally important for the practice of medicine.[25] At least pain relief is acceptable as a goal of medicine.

It would appear that the pursuit of any one or two of the three goals of medicine to the exclusion of others may actually be morally wrong, or at least it might raise moral

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[24] Kenneth L. Vaux: (1988:2140) calls it "*agathanasia*, a better death."

[25] Miller and Brody point out the objection that may be raised—that the supposed third goal of medicine is a question begging way of smuggling in the acceptability of euthanasia. They argue however that there is a separation between this goal and euthanasia. They also cite Daniel Callahan as having argued that the medical goal of helping patients to die well has been neglected.

problems. The problem of euthanasia lies in this area. It can be put by asking whether saving life should be pursued at the expense of patient's loss of dignity, rationality and in some cases, the continuation of excruciating pain. As Miller and Brody point out, there is a strong case for doctors not to kill their patients. But there are cases when both pain relief and healing are not achievable and the prospect of undignified lingering painful death becomes highly probable. In this case, helping the patient to die peacefully and with dignity seems to be the only achievable medical goal. The issue then would be how this should be achieved. Miller and Brody (1995:12) argue that:

> when no healing interventions are appropriate for the condition of a patient who resolutely requests aid in ending his or her life because of intolerable suffering (in spite of careful consideration of comfort care alternatives), then resort to physician-assisted death may become, unfortunately, the best among the limited options available to achieve this important goal of medicine for this patient.

This seems to be related to what Miller and Brody have listed as ethical duties of physicians. For example, we may ask whether or not the duty to practice competently is violated by euthanasia. This duty may be violated if a physician euthanised a patient who could be provided with sufficient palliative care. But if the physician rightly diagnoses that a certain patient cannot be provided with any palliative care and pain relief, he does not violate his duty to practice competently. There is a prima facie case however, for the suggestion that there might be abrogation of other duties if a competent, incurably ill patient in great pain without relief asked for euthanasia and the physician refused.

Let us take a case where a patient is incurably ill, in great pain, and the only medication is to sedate them to a state of coma (Miller & Brody, 1995:11). Providing medical treatment in such a case may breach the medical duty to avoid disproportionate harm to the patient in providing medical benefits. A patient who would rather die than undergo certain painful treatment, or treatment which would leave him comatose, may feel harmed so that the medical benefit may be outweighed by the benefit of death.[26] Miller and Brody agree that the idea of death being a benefit to the dead person may appear paradoxical, but they argue, "if death is a liberation from unrelievable suffering, then it is a benefit. What removes an evil is a benefit, even if the benefit cannot be experienced. Furthermore, it is important not to ignore the benefit to incurably ill patients of knowing that there is a way out if suffering becomes unbearable" (Kass, 1996:14).

The benefit of death may not be the only argument for euthanasia in the sort of case that we are considering. The physician may be violating a duty to refrain from fraudulent misrepresentation of medical knowledge and skills, if he gives the impression that he can handle every case of terminal illness and that all cases of such illnesses can be adequately relieved through palliative care when in fact it may not be the case. As Miller and Brody point out, euthanising a patient is a deviation from normal medical practice in the sense that from a medical point of view, there is no medical indication that the patient is diagnosed as needing "lethal treatment" in the way there might be a determination that a patient needs an operation or psychiatric care. It is

[26] Kass (1996:243) thinks death is not a benefit. He argues "to say plainly, to bring nothingness is incompatible with serving wholeness: one cannot heal, or comfort, by making nil. The healer cannot annihilate if he is truly to be a healer. The physician-euthanizer is a deadly self-contradiction."

evident though that physicians have deviated from normal medical practice. Miller and Brody give the example of clinical research where patients can either be given medication with unproven benefits during trials, or in some cases when patients are given placebos even though it is known that the non-treatment of the patients may lead to complications.[27]

The maintenance of fidelity to a therapeutic relationship with a patient could be threatened when physicians make the patient believe that they can do what they are unable to—that the patient should trust that the physician has all the answers to the patient's illness. Euthanasia could potentially erode that trust between patient and physician. But if patients and doctors understand and agree as to the conditions, which may warrant euthanasia, that trust can be maintained. Does the physician abandon the patient when he knows that the patient is not going to live and yet is not willing to make his passage from this life easier by euthanasia? At most the physician abandons the patient to the ravages of disease. In euthanasia the physician can be understood to be saying to the patient, 'I have stood by you in our common purpose of healing and promoting your health. This is what you and I wanted. Now that we cannot do that, and you would like to end your agony, I am not going to desert you at this point. I am with you and I am willing to help you do that." Euthanasia could be the abandonment of the patient if not carried out accordingly. It could also lead to the loss of trust in physicians. The fact that physicians could euthanise patients does not, on its own, necessarily mean patients would lose trust in them.

It could be that physicians can prepare patients for their death without euthanasia. In that case they would be carrying out the third goal of medicine. But in cases where the physician knows that the patient is dying but he cannot do anything to relieve the patient's suffering, telling them to wait it out until the end does not seem to be a good enough strategy especially if the patient is deeply distressed by the refusal to euthanise him when he earnestly asks for it.

All these considerations suggest that a physician can euthanise patients as a last resort, without violating his integrity, either professional or personal.

Some medical doctors advance the next argument. For example Pellegrino argues that:

> the prohibition against physician participation in euthanasia and assisted suicide has been elemental in the traditional ethics of medicine for a long time. Whether one subscribed to the Hippocratic Oath or not, and whether or not some physicians engaged in "mercy killing," no major professional organization has condoned euthanasia or assisted suicide. Today there are suggestions that the Hippocratic Oath and ethic should be dismantled or declared out of date. But these attempts beg the central moral questions: is intentional, direct or assisted killing of patients consistent with the healing goals of medicine? At a minimum, it would have to be shown that such killing is a beneficent act in the patient's best interests. But this is exactly what is not the case.
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> Miller and Brody's contention that euthanasia and assisted suicide are consistent with the ethics of medicine is simply another step in the dismemberment of the traditional ethic of medicine that has gathered strength in the last quarter century. However one verbalizes the "traditional" ethic—in the Oath of Hippocrates, the Prayer of Maimonedes, its variations

[27] For example AIDS patients given placebos would have the disease progress because of nontreatment whereas some form of treatment could interfere with the disease not withstanding of course, the fact that their belief that they are receiving treatment could have medical benefits for them.

> administered at medical school commencements, or the Code of the American Medical Association—it is inconsistent with euthanasia and assisted suicide. These facts are far from being established morally or accepted professionally. The current fashion for deconstruction of the traditional ethic does not constitute a convincing moral argument for abandonment of a long-standing prohibition (Pellegrino, 1998:86)[28]

The argument that medicine is antithetical to killing does not seem to square with history. At least by the eighteenth century medical ethics was not clearly defined, and the aim of medicine as such was not agreed. Rich patients mainly dictated what doctors were to do and not do.[29] It is also evident that doctors' roles have not confined them to the practice of medicine. They have been involved in government and armies.[30] In Prussia "medicine and law were seen as sister professions serving the ruler."[31] The idea of medicine serving the rulers is also evident in the case of Japan, the United States of America, Britain and Nazi Germany.[32]

One may object that all of this is only good evidence that medicine can be perverted. This is true, but it also shows that some people do not agree on the aims of medicine. It challenges the suggestion that medicine has always been agreed about its aims and

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[28] Rachels (1986:120), who thinks euthanasia and assisted suicide are acceptable seems to confirm Pellegrino's fears when he says that "for a long time the Hippocratic Oath was taken to be such a code, although now it seems to have become more a historical relic than an actual guide. (The oath forbids abortion, for example.)"

[29] It is reported for instance "books of medical ethics began to appear in the latter part of the eighteenth century precisely as part of an attempt by members of the medical profession to develop codes of conduct that would increase professional leverage over their patients. Such works were not profound philosophical inquiries into the theoretical grounds of the duties of doctors, but rather supplements to the traditional gentlemanly codes of honour that had long dictated the proper behaviour of professional men." Lawrance, et. al. (1995:446).

It is also enlightening to note that Percival's "Medical Ethics" "also presented practical advice on how doctors could reinforce paternalism, frankly admitting that charity patients in hospitals could be treated with a degree of authority impractical with wealthy private patients whose foibles had to be honoured." Porter, op.cit., p.284.

[30] For example Nicholas Culpper (1616-1645) "fought in the Civil War on Parliament's side, and was a radical in medicine as well as in politics." Lawrence et. al., op.cit.,p.323.

[31] ibid., p.466. This does not show that doctors were involved in government or in armies. What it does show however is the perception that medicine just like law, were in the service of the ruler. It means once a conflict arises between medical duties and the need to serve the ruler, the latter might be conceived to be paramount. That is true unless the service of the ruler is supposed to involve the medical doctor being duty bound to serve the ruler by and through his patient. This seems to be some evidence for the suggestion that the medical doctors were involved in other things, or at least here it shows there was such a perception.

[32] "In 1936 the 'Epidemic Prevention and Water Supply Unit' was formed as a new Japanese army division. (it was also known as Unit 731). Hundreds of doctors, scientists and technicians led by Dr Shiro Ishii were set up in the small town of Pingfan in northern Manchuria, then under Japanese occupation, to pioneer bacterial warfare research, producing enough lethal microbes—anthrax, dysentery, typhoid, cholera and, especially, bubonic plague—to wipe out the world several times over. Disease bombs were tested in raids in China. Dr Ishii also developed facilities for experimenting on human guineapigs or *marutas* (the word means 'logs'). Investigating plague and other lethal diseases, he used some 3000 *marutas* to investigate infection patterns and to ascertain the quality of lethal bacteria necessary to ensure epidemics. Other experimental victims were shot in ballistic tests, were frozen to death to investigate frostbite, were electrocuted, boiled alive, exposed to lethal radiation or vivisected. … Britain undertook anthrax tests on the Scottish island of Gruinard and at the Port Down research station in Dorset. During and after the war, the American military subjected its troops to secret radiation tests as part of its atomic programme: in the climate of World War and Cold War, it was easy for medical scientists to persuade themselves that their involvement in such un-Hippocratic activities would contribute to medical advance, national survival and the benefit to mankind." Porter, op.cit., p.650.

practices.

Another point to note about the aims of medicine is that there is evidence of shifts in medical ethics. If we take the Hippocratic Oath, for example, we find that it prohibited the involvement of doctors in abortion. Now abortion has been accepted by many medical associations and doctors—to such an extent that in many western countries it is almost taken for granted. It is the same at least with one kind of euthanasia. The American Medical Association, for example, prohibits active euthanasia but allows passive euthanasia.[33] But at times it appears the distinction between active and passive euthanasia becomes so fine that it seems to be just a matter of semantics to refer to letting die rather than killing. This is evident in cases where the giving of certain medicine may directly lead to the shortening of the patient's life and the medicine is given "in order to alleviate pain."[34] This represents a shift from absolute prohibition to the acceptance of passive or possibly active euthanasia.

It is also noteworthy that many of those against euthanasia quickly appeal to the Hippocratic Oath as an authority without much argument to show that the oath does prohibit it without qualification. Another interpretation of the Hippocratic tradition is that:

> the position of "exceptional-case" active euthanasia is grounded in classical clinical wisdom. In the Hippocratic tradition, the physician was discouraged from therapeutically or technologically invading the atrium of death. Attempts to cure had to yield to attempts to comfort. An ethical principle that later transformed Western medicine held that the living ought never to be treated as if they were dying, nor the dying as if they were living. To know the difference entailed discerning the *signum Hippocraticum* (the signs of mortality) (Vaux, 1988:2141).

There is also evidence that the Hippocratic tradition **prohibited** medical intervention in cases of incurable illness. Amundsen says that "the treatise entitled *The Art* in the Hippocratic Corpus defines medicine as having three roles: doing away with the suffering of the sick, lessening the violence of their diseases, and **refusing** (emphasis added) to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless."[35]

This is important in that even though it does not seem to be evident that the Hippocratic tradition recommended euthanasia in cases of incurable illness, it does have implications for starting to treat incurably ill patients. If physicians were to follow the

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[33] Battin (1994:18) points out that "it is often claimed that it is permissible for a physician to administer heavy doses of morphine to a terminally ill patient close to death, knowing that the morphine will depress respiration and make that death occur earlier, provided the physician's intention is to relieve suffering, not to cause the death. There is rarely discussion, in this ideology, of whether the agent also intends the death as well as the relief of suffering, whether the death is intended to relief the suffering, or whether the goodness."

[34] For example Sydney H. Wanzer et. al.: "The physician's responsibility toward hopelessly ill patients" in **The New England Journal of Medicine (March 30, 1989) 320,** p.847 have argued that "in the patient whose dying process is irreversible, the balance between minimizing pain and suffering and potentially hastening death should be struck clearly in favor of pain relief. Narcotics or other pain medications should be given in whatever dose and by whatever route is necessary for relief. It is morally correct to increase the dose of narcotics to whatever dose is needed, even though the medication may contribute to the depression of respiration or blood pressure, the dulling of consciousness, or even death, provided the primary goal of the physician is to relieve suffering. The proper dose of pain medication is the dose that is sufficient to relieve pain and suffering, even to the point of unconsciousness."

[35] Darrel W. Amundsen (1978**:**24.) See also p.25 where he says that the Greek physicians took their duty to abstain from treating hopelessly ill patients as seriously as one might take a religion.

tradition, they would not start treating hopeless cases. If it is wrong/unethical to intervene in a hopeless case as the Hippocratic tradition seems to hold, it might mean that once the physician has started treatment, they extend the patient's suffering if extending the patient's life fails to end the suffering, and therefore have the duty to reduce or end it. [36]

There is also evidence that, throughout history, people have believed that the aims of medicine, and the role of doctors, do not necessarily exclude euthanasia or physician assisted suicide. For example, as far back as the eighth century, John Gregory taught, "it is as much the business of a physician to alleviate pain, and to smooth the avenues of death, when unavoidable, as to cure disease."[37] This is in agreement with Rachels (1986:106), who holds that "the idea that it is all right to allow patients to die is an old one. Four centuries before Christ, Socrates said of a physician, with approval, 'bodies which disease had penetrated through and through, he would not have attempted to cure. … he did not lengthen out good-for-nothing lives."

Pellegrino has argued against euthanasia and physician assisted suicide. However, he does not show that euthanasia in principle is morally unacceptable. Rather, he tries to show that reasons for euthanasia, which are supposed to be acceptable, are not. For example he says, "euthanasia and assisted suicide are not necessary to relieve pain and suffering, not autonomous, not compassionate, not dignified, not private and not a moral obligation of physicians. Moreover they lead inevitably down a logical and psychological slippery slope" (Pellegrino, 1995:73). He thinks that euthanasia is not necessary because what is usually considered untreatable pain is actually inadequately treated pain. The available techniques and medicines are enough to treat any or almost all the pain that can be suffered by patients.[38] He also says that the determination of unbearable pain may be a result of how carers look at patients rather than what patients feel and think.

According to Pellegrino (1995:80), patients' autonomy to seek euthanasia is "dubious at best." This is because depression could be a patient's reason to seek death as they are made to feel the threat of loss of dignity by the way relatives and doctors react to them. This actually alienates the patients who then hand over their autonomy to the doctors and relatives the moment they decide to die. The feeling of alienation and impending loss of dignity reinforces itself. The doctor is normally the one who decides that pain is unbearable, or, that some disease is incurable, thereby in effect exerting some pressure on the patient to accept the inevitability of death.

> Assisted suicide is a noncompassionate act of moral abandonment. It takes the desperate plea for extinction at face value. It denies that "good" death may obtain even when suffering

[36] Vaux (1988:2141) argues, "we must never abandon the cardinal purpose of medical care—to save and sustain life and never intentionally to harm or kill. The other lesson of this case (case of euthanasia) is that we must not destroy the virtue of that commitment by using medical art to prolong dying and puritanically refuse to relieve suffering. This distortion is very possible today, when technological prowess is joined to low rates of bed occupancy and economic distress in hospitals and when our society tends to deny the inevitability of death. If biomedical acts of life extension become acts of death prolongation, we may force some patients to outlive their deaths, and we may ultimately repudiate the primary life-saving and merciful ethic itself."

[37] Porter, op.cit., p.284.

[38] This is contrary to Battin (1994:24) who says "but not all pain, symptoms, and suffering are amenable to treatment." See also Miller and Brody (1995:13). Angell (1995:19) says "modern medicine now performs great miracles, but it also produces great anguish, not all of which can be relieved even by the most assiduous attempts to treat pain."

> is present. How we die is our last act, our last gift to those we love. Those who are dying need the loving company of the living, not their farewell before a life has run its full course (Pellegrino, 1995:83).

According to Pellegrino suffering does not deprive patients of their dignity. On the contrary suffering, depending on how the patient reacts to it, may enhance their dignity. Pellegrino also argues that physicians never have the duty to kill their patients, and he appeals to the Hippocratic tradition. The other argument he advances is that the acceptance of euthanasia may make doctors lax in their treatment of serious illness because they can see an easy way out of the situation, which is killing the patient. Making use of the example of the Netherlands, he argues that the slippery slope argument is not idle talk because euthanasia started off as few strictly controlled cases but eventually growing into involuntary euthanasia.[39]

Wolf has also advocated banning euthanasia. She examines paediatric euthanasia and argues that voluntary euthanasia will lead to non-voluntary euthanasia. She also points to developments in the Netherlands and argues that paediatric euthanasia is different from adult euthanasia because the former does not involve patient autonomy. The acceptance of voluntary euthanasia leads to paediatric euthanasia as evidenced by developments in the Netherlands. She also fears that the introduction of euthanasia may see the lifting of safeguards against abuse. Paediatric euthanasia is against beneficence and the Hippocratic Oath. Euthanasia may usher in the eradication of disease by the eradication of patients. The only answer she thinks is the improvement of pain relief and good patient care.

Pellegrino and Wolf have one argument in common—the slippery slope. I think on its own it does not help us very much. It does not tell us why euthanasia should be considered to be morally wrong except by pointing out the alleged consequences. The fact that it may lead to other practices does not necessarily make it wrong. For example, one may argue that the fact that the introduction of abortion under restricted conditions led to abortion on demand in some cases (if it has) does not mean abortion under those special conditions is wrong (that is, if abortion on demand is wrong).

The psychological argument advanced by Pellegrino does not show the wrongness of euthanasia, either. It only shows us the possible explanation of certain patients' request for euthanasia. It does not rule out situations where the psychological legitimacy of a patient's request for euthanasia is not in question. Likewise, the argument does not address the principle of euthanasia being morally acceptable. This leads us to examine the case for euthanasia to see if it can be made.

The general arguments in favour of euthanasia are that patients have autonomy that may be respected by doctors when the patients express their will to die. The arguments begin with the fact that everyone has the right to determine their life. They can decide to die in pursuit of their autonomy (self-determination). If they can make this decision, they have the right to ask for help from others[40] if they cannot bring about this death

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[39] "In the latest report from the Netherlands," Pellegrino (1995:88) argues, "euthanasia has been progressively extended to infants, children, patients with psychiatric disorders, and patients with nonterminal illnesses. The empirical fact of the slippery slope is undeniable in the one country in which euthanasia has quasi legal status."

[40] This may raise controversy since it affects other people's autonomy, in this case the would-be assistants whose autonomy may be served by refusal to kill the patient. It is clear though that "aganathanasia" or euthanasia practitioners should be free to euthanise patients if they want.

themselves.[41] The other argument for euthanasia is from mercy. Some diseases are so ravaging that patients experience untold misery and cause their relatives, carers and friends anxiety and pity. When patients are suffering and they are unable to kill themselves others should do so on their behalf as an act of mercy.

It has also been argued that physicians have a duty to their patients. The duty is to save the patients' lives and also to alleviate their pain when it cannot be cured. Physicians have the duty of beneficence, which does not exclude mercifully killing their patients at least in some cases. Pain relief is compatible with euthanasia because physicians have another duty to help their patients exercise their autonomy that may involve euthanasia, and a physician would not let his patient suffer needless pain. Euthanasia is not equivalent to harming patients.

Many people seem to accept that at times patients may be ill to a point when stopping treatment for them may be morally acceptable, and at times, mandatory because of the futility of treatment.[42] This can happen with or without the patient's approval. Sometimes the patient is unable to give consent and 'substituted judgement' is used to arrive at a decision. That is, somebody makes a decision based on what the

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[41] This is a controversial statement. One may argue, for example, that if someone decides to become a great pianist, they do not have the right to expect help to make him or her pianists. The first thing is to accept that the person has the right to become a pianist if they want. Once we grant that we would have to expect that at least they should not be impeded to pursue that right as long as they do not threaten any other right holder and the pursuit of his own right. Now if the person has the right to be a pianist, it means somebody could provide the basic education for this person as a matter of duty. For example, it is commonly believed that societies and governments have the duty to educate their citizens. Now, if the government for example has the resources to provide the education in piano music they would have the duty to provide this education to this student if he qualifies. Once the institutions and others have provided what they can, he can go on and become a great pianist. The institutions against which he can claim his right to be educated in piano music would have provided the basic foundation. The parents may also be obliged to educate their children. So the child can claim the right to be educated in piano, and if the resources are there, get the basic skill, which will enable him to go on to greatness. The question at issue here is whether or not once one has a right others have the duty to help him exercise it. It would seem to depend on the situation.

[42] Even those against euthanasia accept letting die and the doctrine of double effect tries to address this. See Childress, (1998:120-147).

"In 1982 the AMA in "Principles of Medical Ethics" say: "Quality of life is a factor to be considered in determining what is best for the individual. Life should be cherished in determining disabilities and handicaps, except when prolongation would be inhumane and unconscionable. Under these circumstances, withhold or removing life support means is ethical provided that the normal care given an individual who is ill is not discontinued. …

The social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have discretion to resolve the conflict.

For humane reasons, with informed consent a physician may do what is medically indicative to alleviate severe pain, or cease or omit treatment to let a terminally ill patient die, but he should not intentionally cause death. In determining whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient, the physician should consider what the possibility is for extending life under humane and comfortable conditions and what are the wishes and attitudes of the family or those who have responsibility for the custody of the patient.

When a terminally ill patient's coma is beyond doubt irreversible, and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support systems may be discontinued. If death does not occur when life support systems are discontinued, the comfort and dignity of the patient should be maintained." (Rachels,:90-91).

patient would have decided were they to make the decision (Battin, 1994:8). In the case where the patient's wish cannot be established what is considered to be in their interest is usually done, including stopping treatment.

When a patient dies because treatment has been stopped, as when a life support system is switched off, some people believe such action is morally different from active euthanasia. It is so-called passive euthanasia, and it is supposed to be morally different from killing. Many doctors seem to be involved in the former. Supporters of the distinction between letting die and killing who are against euthanasia think doctors should be involved in deciding to let patients die. Or at least there are cases of letting die that are morally acceptable. I think such a view has been well challenged. Rachels (1986:5) for example, argues that:

> the distinction between killing and letting die is morally insignificant as well: the fact that one act is an act of killing (for example, 'mercy killing') while another act is an act of 'merely' letting someone die (for example 'pulling the plug' of a life-sustaining medical device) is not in itself a reason for thinking one act morally better than the other.

He ably demonstrates the point by giving the example of a terminally ill patient whose life cannot be saved and the pain inevitable. In such a case, there are three options. The first is to treat the patient. If marginally successful, the treatment will prolong the patient's life for a few hours or days. But that would not alleviate the pain and suffering. So it means few more hours or days of excruciating pain for the patient. This option does not seem to be good for the alleviation of suffering. The second option is to let the patient die by either withholding or omitting treatment. The result is that the patient dies but after suffering for a while. This option leaves the patient a bit better off than the first one, but it is not adequate as the patient still suffers. The third option is to give the patient a lethal injection which then kills the patient with much less pain involved than the other options. Those who argue that it is wrong to give the patient a lethal injection in the given example should justify the pain suffered by the patient when he awaits the natural progression of his disease to death. It appears that if pain alleviation is so serious as to be decisive in determining whether or not the patient should receive further treatment, then it should not be omitted when it involves direct killing. The omission would be a refusal to take responsibility. It is like somebody who says to a starving person, 'I hope somebody gives you food soon' but does nothing when he has the food he could give. The problem seems to be the pretence that people do not want the patient to die. It does seem to be true that letting die cases are ones in which doctors, patients and relatives want the patient to die, but hope it can happen without anyone killing him. The morally right thing to do seems to be the acceptance that killing a human being is nerve-wracking and morally upsetting, but sometimes better than the alternative. There is nothing rationally wrong with such a position. I agree with Rachels (1986:113-114) when he says that:

> if a doctor lets a patient die, for humane reasons, he is in the same position as if he had given the patient a lethal injection for humane reasons. If the decision was wrong—if, for example, the patient's illness was in fact curable—then the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, then the method he used is not itself important..

The alleged difference between killing and letting die is that if a doctor killed his patient, he would have actively done it and in a very direct manner. Thus, he would be

the cause of the death. In letting die the doctor is not the cause of the death but the disease. That is a crucial difference, so goes the argument. However Rachels (1986:115) seems to be right when he points out "there is nothing wrong with being the cause of someone's death if his death is, all things considered, a good thing."

The other objection is that when the doctor does not help the patient, he should not be judged as if he has killed him because his duty to help in this case is less stringent than the demand against killing. Thus, if one cannot help, at least one should not cause harm. Even if this is acceptable, it does not seem to be clear that a patient who cannot be helped to live longer and wants to die, with all agreeing that it is good for him to die, is being harmed when in fact he gets his wish granted. Besides, it is not very clear that desisting from causing harm is more stringent than the duty to help. Rachels has ably demonstrated that there may be equivalence between the two. [43]

The other argument commonly resorted to in favour of the moral distinction between letting die and euthanasia is the doctrine of double effect. According to this principle doctors can "escape" the moral responsibility of killing their patients by giving medication, which they know shortens the lives of those patients. They can give the medication to alleviate pain. When the patient dies it is not what the doctor intends, but death is the effect—and the foreseen effect—of what he has done which is not by itself a bad or wrong—of giving medication that alleviates pain. For me the double-effect argument is like the defence of someone who kills in self-defence, where it is suggested that the death of the attacker is not intended when he shoots the attacker in the head. It seems to be more honest to say that he would have preferred to avoid the death of the attacker, but, as things are, it is his intention to kill the attacker. The would-be victim intends to shoot in order to kill if that is what it takes to defend himself or to stop his attacker killing him. His intention is justified by the legitimacy of his right to self-defence. In the case of the doctor and his patient, he intends to alleviate the patient's pain. He intends to do this even if he kills the patient. It is accurate to say that he intends the death of the patient even though he would rather not have killed the patient. In short, when a person does something with the moral certitude about its result it is not true that he does not intend those results. He cannot separate his action from the known results of that action in as far as his intentions are concerned. He might not like one of the results of his action, but that is different from saying that he does not intend it. There is no way to go around the effect of death in this case because it is so crucial that it determines the morality of many actions.

Quite a number of doctors accept the morality of some cases of euthanasia. According to Angell (1995:19) "polls of doctors indicate that a majority of them, like the public at large, believe that assisted suicide or euthanasia is sometimes appropriate.

[43] I agree with him when he criticises Trammel who gave the example of an armed robber in attempting to prove that killing is not equivalent to letting die. He says that faced with a robber threatening to kill another person unless I give him my thousand dollars, I have more right to keep my money even if he shoots the man than I would have to shoot him to keep it. The problem with such an argument is that it appears to assume without demonstration that one of the decisions is morally worse than the other. If Trammel does not believe that he is not obligated to save the possible victim as much as he has the duty not to kill him, how does he come to conclude that not saving the victim is better than killing him? It seems to be the case that if Trammel did not feel equally responsible to save the victim it does not necessarily mean he actually does not have the responsibility. It seems to be the case that just as a thousand dollars is not worth killing for, it is not valuable enough to be preferred to the life of a person. The argument does not account for the fact that omissions can be grounds for blame as much as commissions.

But among these doctors, about half believe that the act should be performed by someone else, not a doctor. They believe that a doctor's function must be to extend life, never to shorten it."[44] The doctors' view seems to suggest a separation between medical and ordinary morality, a position that we rejected in chapter two.

The justification of euthanasia is mainly based on autonomy: every individual has the right to live his life according to what he thinks is right, and nobody has the right to disturb him in his pursuit of this life as long as his behaviour does not interfere with others. This right is duly recognised when patients decide to take certain medication which may kill them or when they refuse to take medicine resulting their death (Loewy, 1998:49). Now if people can kill themselves for whatever reason,[45] as long as they decide it is legitimate for them to do so, it appears they have another right, consequently, to try to enlist assistance to realise this right if and when they cannot do it themselves.[46] This also confers another right, namely that others should not impede the subject when he acts in pursuit of his right. Loewy even suggests that when a dying patient refuses treatment in the face of hopelessness, and the carers including doctors help him, they are helping what is effectively a suicide.

One of the problems, however, is that even if euthanasia and suicide are morally acceptable in general, the conditions of typical euthanasia cases exclude understanding and freedom. If autonomy can be exercised by people only when they are free from pressure and ignorance, how can patients, who are so ravaged by disease, exercise their autonomy to kill themselves when they are terminally ill and under immense pressure? This is what Pellegrino (1995:80) was sensing when he said that patient autonomy was "dubious at best." The fears, biases and attitudes of doctors, carers and relatives may not help the enormous psychological pressure on the patient. Indeed, the apparent finality of imminent death, the fear of almost palpable loneliness and the feeling of estrangement of the patient can hardly be said to be allies of autonomy.

Angell has suggested that a patient may reject medication for whatever reason. Competence to make such a decision does not demand a rigorous standard. All that is needed is that the patient understands the nature of the decision. For example the patient has to understand that cessation of medication will lead to death which is currently irreversible. Competence, according to Angell (1995:8), "does not mean making a decision that most of us would find sensible." Patient autonomy means doing what the patient wants "no other standard takes precedence—not even the patient's best interests."

Even if we were to concede that sometimes patients make decisions that are

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[44] Willard Graylin, et. al. (1988:14) do not accept euthanasia on the same basis. See also Wanzer et. al. (1989:320).

[45] Not all cases of suicide are beyond criticism because suicide is freely decided upon. For example it can be cowardly, self-indulgent or melodramatic. But here we are considering cases where more serious reasons are the cause.

[46] Rachels (1986:80) says "afterall the only difference between suicide and euthanasia is that, in the former, one does the deed oneself, while in the latter one solicits the help of others. And if it is permissible to do the deed oneself, how can it be wrong to enlist aid?"

Glover (1977:188) thinks "it reasonable to regard voluntary euthanasia as acceptable in principle in those cases where helping someone commit suicide would also be justified."

Loewy (1998:49) thinks "if we believe that in most instances persons have a right to self-determination as long as this self-determination does not in a significant way harm others—it is difficult to see how one would argue against an at least conditional right to commit suicide."

supposed to be for their own good when in fact they are not, and that diseases such as mental disorder can sometimes cause loss of autonomy, it is not the case, and we have no reason to think, that every suicide and request for euthanasia is a result of pressures which remove the patient's autonomy. In fact, it is arguable that some requests for euthanasia and suicide are rationally based. J.L Werth (1996) argues that some requests for euthanasia and suicide are made following rational deliberation. This is based on research carried out on AIDS and cancer patients.

Socrates willingly went to his death in what some may call a legally sanctioned suicide. The Stoics and Epicureans had a rationally based acceptance of euthanasia and suicide, and Rachels (1986:8-9) reports:

> it seems that a wise person will not avoid death at any cost, but will chose it at the right time. Seneca, again, wrote: I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys my faculties one by one, if it leaves me not life but breath, I will depart from the putrid or the tottering edifice. If I know that I must suffer without hope of relief I will depart not through fear of pain but because it prevents all for which I would live.

He goes on: "it is said that Bentham himself asked for euthanasia in his last hours" (Rachels, 1986:19). Freud was also reportedly euthanatised (Battin, 1994:30). A rational suicide may imply that euthanasia be allowed in those cases that could be acceptable as suicide. Now if rational euthanasia is possible and a right, there are at least those cases that in principle are allowed—of suicide and euthanasia.

The other argument for the acceptance of euthanasia is that from "mercy."[47] Battin (1994:265) says "the principle of mercy requires not just refraining from causing pain or suffering, which the principle of nonmaleficence would require, but also acting to relieve pain or suffering as the principle of beneficence would require." This argument is demonstrable by the use of an example given by R.M. Hare (Rachels, 1986:159). A person finds himself in the unfortunate situation of being trapped in a burning tanker. He asks those nearby to kill him so that he will not have to endure the burning fire. One of the people does. It is plausible that this is a case of morally right euthanasia. The people could not save his life, but they could save him from the ravages of fire. Mercy and pity moves the man who kills this fire victim. Likewise, doctors can find themselves faced with patients they cannot help save from disease, and if they have mercy at all, can save them from at least the pain of disease from which they long to be freed. Angell (1995:19) argues "the real business of medicine—to provide care in whatever way best serves the patient's interest. If acceding to a patient's request to hasten death seems appropriate to the doctor, how can he or she justify withdrawing from the patient's care at that point? The greatest harm we can do is to abandon a desperate patient."

Rachels (1986:84) also brings in a fresh argument to the euthanasia debate. He argues that even though Kant did not approve of euthanasia, the application of his principle of categorical imperative seems to imply its moral legitimacy. The principle states, "we must *be able to will* that a maxim of our action should become the universal law. This is the general canon for all moral judgement of action" (Kant, 1991:86). Put

[47] The word "mercy" may not be accurate because one shows mercy when he refrains from inflicting pain he might justifiably inflict. Making pain stop is not inflicting. May be pity could be better. Let us take it to be used technically in this context to mean the emotion that moves one to help a suffering being.

another way, "there is therefore only a single categorical imperative and it is this: '*Act only on that maxim through which you can at the same time will that it should become a universal law*'" (Kant, 1991:84). If we take this principle we find that a person in the situation of Hare's example given above would like people to help him die quicker. Many people would most probably agree that he has a legitimate expectation in hoping for such help. If he is willing to have other people kill a human being (him) in his situation he should equally be prepared that others would expect the same of him and indeed of all rational beings. The man who killed him should be prepared that if he finds himself in a similar situation somebody would help by killing him. Rachels (1986:158) says of the case, "if we would not be willing for the rule to be followed universally, then we should not follow it ourselves. Thus, if we are not willing for others to apply the rule to *us,* we ought not apply it to *them*. The rule to be applied in this case is that when I am desperately ill and there is no hope of saving me, others should kill me and I should he prepared to kill others in a similar situation.

The importance attached to human dignity by Kant may imply that whatever threatens to undermine that human dignity in a person should be done away with. Disease can arguably be so severe that it might undermine its victim's human dignity. So euthanising a patient may actually be consistent with Kantianism. Ergo, euthanasia in the cases that threaten human dignity is morally right.

Medical doctors are not only allowed to euthanise their patients in certain cases; in some cases they have the **duty** to do so. Battin (1994:27-28) has argued along these lines and said that patients have the right, not just to die if they so desire, but to do so without suffering or at least with as little of it as possible and with dignity. This right is violated and the autonomy frustrated when it cannot be exercised because either the patient is unable to kill himself or because not being able to kill himself, those who can do not help him. She argues,

> at a minimum the physician is obligated to refrain from attempting to prevent the suicide, whether by threat, force, or involuntary hospitalization. And insofar as the patient's right becomes a positive claim to assistance, the physician, as the party most knowledgeable in medical matters, must provide help in doing what the patient seeks. And because the patient's trust and comfort with a familiar caregiver is also crucial in seeking an easy death, the obligation to assist is particularly strong for the patient's own physician.

The decision to die is the patient's and the doctor should help him to exercise his autonomy. Because at least some information is necessary for one to make a rational decision, the patient needs to be adequately informed of his condition so that if he has to decide whether or not to commit suicide, or when he cannot, be euthanised, he should have time to do so.[48] If the doctor allows the patient to fall into coma without having given him the relevant information (suicide and euthanasia options and their probable necessity), he would have deprived the patient of the exercise of his autonomy and therefore the doctor bears moral responsibility for that. The issue here is more about the patient's autonomy and rights than about the doctor's values and attitude. Even a doctor who objects to euthanasia may have the duty to help if he did not raise the issue well in time with the patient. Probably this is what the Hippocratic tradition wanted to avoid in making it a physician's duty not to treat desperately ill patients. Battin (1994:41) argues,

[48] See also Wanzer (1989: 345).

> to put it in another way, the physician's obligation to help arises primarily within a relationship that develops during the course of providing care for a dying patient. As time goes on and the patient's condition declines, the patient's rights grow stronger both on grounds of self-determination and of mercy, and thus the physician's obligation grows correspondingly more difficult to evade.[49]

One of the objections to euthanasia is that doctors should be benevolent and not malevolent. They should do good and avoid doing harm. The supposition in rejecting euthanasia and its medicalisation is that it "harms" the patients. This supposition is evidently debatable; because many would agree that killing the trapped man in Hare's example does not harm him—at least not in the sense of a murderer harming his victim. Killing a human being and a person (if there is a moral distinction) is not always harmful to them. Loewy suggests that harming somebody means injuring or causing him or her unnecessary pain. If we accept this definition then reducing pain cannot be harmful to the patient under certain conditions.[50] The doctor actually has a duty to euthanise the patient if he cannot help save his life because "the function of medicine is not only that of sustaining biological life but, and at least with equal force, that of relieving suffering" (Loewey, 1998:56).

Moreover, there are two sides to causing harm. There is the objective aspect where everybody would agree that murdering someone is harm to the victim. The assumption is that the victim does not want to be murdered as well. Then there is the other side of understanding harm—the subjective part. The subject of harm seems to be an important part of the whole equation. This means for a full harm to occur, there should normally be some kind of both objectivity and subjectivity of understanding that harm. The problem then is to decide which, if any, of the two aspects is morally more important than the other. Unless we want to endorse wholesale paternalism, we are likely to be inclined towards the suggestion that subjective harm is more important. This is because issues of autonomy relate more to the subjective self than to the public or objective perception. It goes back to the importance of autonomy—if self-determination is morally more important than what people may think is good for the person, then the perception of harm by the patient is more morally important than what other people may perceive to be harm. This means if a patient thinks it is right that he should be allowed or helped to die, it would be a great harm to him should other people feel and act otherwise. Euthanasia may after all be consistent with the doctrine of nonmalevolence.[51]

One of the objections to euthanasia is that it may promote callousness in doctors and encourage people to quickly resort to euthanasia instead of other options. Loewy

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[49] What Battin seems to be arguing here by saying that "the rights grow stronger" is that the more desperate the patient's condition he is in a more powerful position to have help from the physician. That is, the physician is more obligated to assist him since he can help the attainment of the patient's will thereby ensuring his autonomy is respected. The doctor would also be obligated to help because of his mercy for the patient.

[50] On the other hand, reducing pain can be harmful to the patient. Consider a situation where pain can only be reduced by drugging the patient to the point of a vegetable state. Such means of reducing pain would not necessarily be good for the patient especially if he expressly and vehemently disagrees with treatment that leads that direction. That would be a kind of harm to him, at least from his point of view.

[51] Porter (19:701) "Euthanasia my be squared with professional ethics of the physician and with common morality through the argument that, while it is the doctor's duty to save life, that duty does not run so far as to prolong life through artificial means in all circumstances. The Hippocratic Oath merely required that the physician should do no harm."

(1998:80) has pointed out that "forcing patients to die slowly and in pain rather than allowing them, at their own choosing, to end their existence with dignity and in peace reinforces callousness." What else can we call a situation whereby people say that they care about somebody and yet hold that they do not want to grant him what he has existentially experienced as the right course of action, but callousness? This is what happens when people try to tell a patient that his suffering is good for him and he and other people should not do anything to end it.

Furthermore, there is evidence that the availability of euthanasia in certain cases does not necessarily lead to unnecessary requests for it. Angell (1995:20), for example, has argued that it is actually the anxiety about not being able to get help when the time comes for them to die that patients may decide to terminate their lives prematurely when they can do it themselves. Otherwise, if they knew that help would be available when they need it, many patients would live happier lives before the time to die comes. She gives an example of a woman who lived peacefully after stockpiling sleeping pills with which to commit suicide if and when the time came.

The considerations in this chapter suggest that euthanasia may be morally justifiable. People's autonomy means they may be morally right to commit suicide. Once that is acceptable, the implication is that euthanasia or physician assisted suicide is equally justifiable. The other argument is that mercy implicates doctors in euthanasia—they have to do it as an act of mercy for their suffering patients. They also have a duty to support the autonomy of their patients, which may mean having to euthanise them. This can be done according to Miller and Brody, violating neither personal nor professional integrity.

The implication of this for medical doctors is that they may sometimes kill without violating medical ethics or committing a moral wrong in some cases of euthanasia. Medicine does not necessarily exclude doctors killing patients. What is the relevance of all these to the medicalisation of capital punishment? There is at least one important implication: the medical role does not necessarily exclude killing. This is important because the major objection to the medicalisation of capital punishment is that doctors should not kill. The medicalisation of euthanasia also helps to show that killing at least in some cases does not necessarily violate even medical ethics. This means the argument about doctors not being involved in killing is not available to those who oppose the medicalisation of capital punishment.

Now if euthanasia is in principle morally acceptable and doctors may be involved in it, what about medical involvement in capital punishment? Is there a moral difference between the two? Loewy has addressed the relationship or possible implication of euthanasia to the medicalisation of capital punishment. He thinks that the two are different in a morally significant manner. A patient in the case of euthanasia knows the options of survival and death; at least they are known or knowable. It is known that he is likely to die by a certain time and that he might never recover. It is also known that the pain and suffering he endures will continue as long as he is alive and the only option out of the situation is euthanasia. In the case of a condemned prisoner it is not known what will become of him if he is not executed.

It does not seem to be true that the prisoner's options are not known or knowable. We are pretty certain that once all the legal requirements have been fulfilled the prisoner will die a certain kind of death that is likely to be more painful than if it were

medicalised. If the execution should be by lethal injection the medical doctor is the one well placed to do it both from a technical and professional point of view. Loewy (1998:65) himself acknowledges this when arguing for euthanasia.

He argues that:

> above all else, physicians must never utilize tools (actual as well as conceptual) acquired in the process of medical training for patient's detriment but always for their patient's good. The reason physicians must not use the tools of medicine to knowingly harm patients resides in the social contract in which physicians and their community are enmeshed. Medicine is a social task, and the mission of medicine is ultimately one which is developed by physicians and their communities in an ongoing and dynamic fashion. The assumption that physicians will seek to bring about their patient's good and never knowingly seek to do them harm has persisted throughout history and persists today. It underwrites the trust which patients must necessarily put in the health care professionals they consult.
>
> Unquestionably, not executing healthy persons is a part of "not doing harm." It is clear that, since the options are unpredictable and wide, the good of criminals (even should they conceive otherwise) may not be served by execution. Patients dying a painful death are a different matter. Their options are few: they can either die in prolonged agony or, more mercifully, can choose to end their days more easily and earlier. Helping patients to die who, under such circumstances, seek to end their life is quite different than killing patients whose options are unknowable and who, for the most part, do not want to die (Loewy, 1998:58).

The argument that physicians should never use their knowledge to the detriment of their patients in itself does not give us more information. A lot seems to depend on what Loewy would mean by "detriment." He acknowledges that doctors should be allowed to kill their own patients in the case of euthanasia.

If physicians and their community have a social contract that regulates the patient physician relationship, it would not necessarily preclude the medicalisation of capital punishment, especially when we acknowledge that capital punishment itself is a social act. If society determines that capital punishment is morally right (supposing it does) and if physicians develop (to use Loewy's terminology) a medical mission that is "dynamic", there is no reason to suppose it would never consider including the medicalisation of capital punishment in that mission. It seems more probable that once the community thinks that capital punishment is morally right, and it has the right to fashion a medical mission, it should be able to merge the two into one consistent perspective—medicalisation as part of the medical mission.

People think that there is something morally wrong with killing a healthy person, especially when such killing is against his will. That is a reasonable point of view. But rather than raise problems for the medicalisation of capital punishment, it does for the morality of capital punishment itself. If, as the medical associations hold, the morality of capital punishment does not matter,[52] there is no specific reason to object to medicalisation unless one objects to the killing of a healthy person. But then to say that capital punishment is morally acceptable is equivalent to holding that killing a healthy person is morally permissible in some cases. To be agnostic about or indifferent to the morality of capital punishment as the medical associations are seems to be in need of a justification. So if we show that the society, which determines the mission of medicine as, suggested by Loewy can approve the medicalisation of capital punishment because it

[52] Even Miller and Brody (1995:15) hold that "our stance is not based on a judgement that capital punishment is immoral. Whether or not it can be morally justified, physicians should not be involved as executioners."

deems it to be morally acceptable, we have done enough.

The objection to the medicalisation of capital punishment by Amnesty International for example is based on their belief that it is morally wrong. So they would like to see executions stopped, and their objection to medicalisation is part of a bigger debate. For them medicalisation would be the use of medical knowledge and ability for something that is wrong. This is significant because if things were to be arranged as Amnesty International recommends, executions should stop and therefore the medicalisation debate would be unnecessary. The medical associations however are officially neutral as to whether executions continue or not; they only insist that if they continue, doctors should not be involved. This is important because, if and when the government has determined through the legal system that the prisoner should die, he then does not have an option but to undergo execution as long as the decision to execute him still stands. So from that point on his options are more or less known even to a greater extent than a patient who might have a spontaneous remission of his condition which the medical apparatuses are unable to determine before hand. For the prisoner we know too well that if the execution is scheduled to go on and the will to execute is there, the prisoner will be executed. So even applying Loewy's standard the prisoner would qualify.

The freedom/autonomy of an individual may be influential in determining the outcome of a moral assessment. In the case of euthanasia the argument is that patients are exercising their autonomy in deciding to be euthanised, and that should be respected. This aspect is absent in the case of a death row prisoner, or at least many of them who would rather live than die. There are a few prisoners who want to be executed. In their case it might be that they should be granted their wish, or if granted, doctors should execute them on the basis of autonomy and mercy just like the patients in euthanasia. So the argument from autonomy would actually seem to justify the medicalisation of capital punishment when prisoners choose to be executed by lethal injection especially.

Here we might have to accept that if autonomy is such an important thing, doctors would rightly refuse to execute prisoners against their will just as much as they would desist from practising "compulsory euthanasia." This would stand on the assumption that individuals' autonomy is always supreme and can never be overridden by anyone. If it is a fact that society has no right to override the autonomy of a patient, does it follow that it does not have the right to override that of a prisoner? Implicit in the moral acceptance of capital punishment is the idea that the individual autonomy of the prisoner can be overridden by society subject to certain conditions. So autonomy in the case of a prisoner may not necessarily be as decisively against the medicalisation of capital punishment as it is decisive in favour of voluntary euthanasia.[53]

One argument for euthanasia is that some patients have already lost their personhood or biographical life even though they retain their biological one or human being status

[53] There are a few issues that need to be clarified at this juncture. The first is that Kevorkian-type of operation by doctors should not be construed from what I have said above in relation to the euthanization of patients. Patient autonomy is not the sole determinant of euthanization. There is the issue of incurability of disease, the doctor's own moral sentiments and the degree to which a particular case is consistent or inconsistent with the dictates of medical ethics. Conscientious objection is allowed; as for example in the case of abortion not all doctors are required to carry them out. This can also be the case in the euthanization of patients.

Prisoner autonomy is also important so it cannot be disregarded without due consideration. But what I would argue is that certain conditions might be such that prisoner's autonomy may have to be set aside.

(Rachels, 1986). So euthanising them would not be of the same moral status as killing persons with biographical lives. The same argument is used for abortion and infanticide. This supposes that there is a moral difference between biography and biology. If some patients, foetuses and infants are in that way less morally problematic to kill than persons, the same cannot be said about death row prisoners who have biographical lives. If one were to argue that prisoners are insane, then they should not be in jail but in hospital, and their conviction for murder was a miscarriage of justice. The assumption is that they were biological persons when they committed their crimes. The issue then is why should morally important persons be put to death? Persons with biographical lives can be killed as argued above (the rational choice of euthanasia). The difference however is that the euthanasia persons can be killed in pursuit of their autonomy. This is not the case with prisoners. The argument about individual autonomy vis-à-vis societal powers should apply here as well. This will also be reinforced by the argument from innocence. If it is morally wrong to kill an innocent person, is it the same in the case of a guilty prisoner?

If the arguments advanced above are acceptable, one can conclude that euthanasia is morally acceptable, at least in principle. This establishes the fact that doctors can actually kill persons without violating medical ethics when they euthanise their patients. The medical mission to heal patients and act in ways that benefit them is not necessarily violated by euthanasia. Patient autonomy and physician mercy may be grounds on which euthanasia can be carried out, and they could be used to make a case for medical involvement in euthanasia.

Once euthanasia is morally acceptable it might imply that the medicalisation of capital punishment cannot be rejected simply because it involves doctors in killing persons, doctors can after all do so without violating the aims of medicine. It shows they have other duties than life saving. I have suggested that if the mission of medicine is dynamic and a result of social decision as suggested by Loewy, then it appears this can be useful for the medicalisation of capital punishment. This is so because if society decided that capital punishment is morally acceptable, society can decide that executions be part of medicine's mission. This would be better than executing prisoners painfully—without medicalisation—lethal injection.

CHAPTER 4

THE MILITARY DOCTOR

Let me first restate the issue that I wish to address in this work. The medical associations hold that doctors should never kill. In this chapter I argue that medical professionals sometimes have duties beyond their medical roles, duties which may even appear to conflict with their medical role. This is exemplified by medical doctors' involvement in roles beside the medical one, for example as an army doctor. The military doctor is a role that seems to contradict the aims of medicine. The doctor is attached to a military force and promotes its aims, which can include killing as many of the enemy soldiers as possible. The military doctor also repairs patients to go back to life-threatening situations. This chapter does not seek to justify the existence of armies; neither does it seek to show that armies should not exist. It argues, rather, that since armies kill in their attempt to protect people, military doctors are or may be involved in either killing or helping those planning to kill people. This is apparently against the medical profession's ideal of saving human life. So it seems to be arguable that medical associations should be against the military doctor role.[54]

I argue that in fact, hardly anyone objects to the existence of military doctors. This may be because it is justifiable on grounds external to medical ethics. Perhaps the same thing can be said of doctors' involvement in penal institutions.

The first question is whether the military doctor is a soldier who is medically qualified, or a doctor who works in the army. The military doctors work for the army and have military ranks. They are assigned military duties. To be a doctor means having medical training, practising medicine and being guided in one's actions by medical ethics. In other words, doing only those things that all doctors would do and desisting from doing those things that all doctors would not want to do and should not do. Are military doctors soldiers first and doctors second in the above senses of "doctor" and "soldier"? All three of my military doctor informants told me that they are doctors first and soldiers second.[55]

Contrary to that view, we see that the military doctor is certainly different from an ordinary or civilian doctor. Besides the fact that they belong to a section of society that sometimes has to kill people (army), they do what other doctors are prohibited by medical ethics. Doctor-patient confidentiality is not the paramount principle in the army. In interviews with me, Colonels Lawrenson and Baker of Colchester Garrison

[54] This echoes Elizabeth Haldane, who has argued, "she who binds up the wounds that war has made has also helped that war to be carried on" (Summers, 1988:203).
[55] Personal interview

Medical Reception Centre have both pointed out the fact that as members of the Royal Army Medical Corps, they are currently obliged to divulge information about the sexual orientation of their patients to the army authority.[56] If their patient is gay they have to tell the army leadership. This is clearly privileged information that they only get because they are playing the medical role.

Elaborating further on whether military doctors are soldiers first and doctors second or vice versa, Colonel Baker said that, in his experience, most military doctors are more "doctors in uniform than soldiers." I understand this to mean there is tension between military behaviour and their medical duties. The doctors lack the military attitude. He also suggested that many military doctors he knows did not go on to become successful civilian general practitioners. Probably this is caused by the fact that as civilian doctors, their patients are different from soldiers. Their relationship with patients is significantly altered. The army doctor is still a military officer of usually higher rank than the ordinary soldier is. In many cases the doctor patronises the junior soldier. Their relationship is that of superior and subordinate. This is not the case with civilian medical practice.

Colonel Baker thinks that military medicine is an unusual kind of practice. "It is not like working for Marks and Spencer," he told me. He observed that a military doctor is not independent and may not act independently of the army in terms of its objectives. The military doctor is "sucked into the system". Thus, he is part and parcel of the military. The military doctors hold ranks in the army. That makes them part of the army administrative structure, which involves disciplining and controlling junior officers. Colonel Baker thinks there is tension between an individual soldier and the military system or machinery. The military doctor has to play a very difficult role of balancing their duty to the individual soldier/patient and the system that the doctor represents. An example is the methods of discipline. Physical punishment is part of the military discipline (press-ups or sit-ups etc may be painful for the soldier to a point where they are almost torture). As part of the administration the doctor is party to a system that uses physical punishment on members, whereas as a doctor they may have to be reconciled to the fact that their patient had the illness (when soldiers need medical treatment as a result of punishment) inflicted upon them. That is a highly unusual situation for a doctor

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[56] This is no longer the case as a recent court ruling makes the discrimination of gay soldiers illegal. The ban on gay soldiers was lifted on the 12th January 2000. Metro, "Ban on gays in the forces is scrapped." in **Metro**. London. Thursday, January 13, 2000, pp.1-2.
See also Appendix 2: Hurst, personal correspondence, pp.1-2 who says, "I am interested to see that doctors are expected to break patient confidentiality in terms of homosexuality. This may have been the case, although I would question their role. The military now adopted, informally anyway, a no ask policy. As an Officer, if a person discloses they are homosexual to you, you have to report it to the authorities. I guess it only becomes a medical in confidence issue if you consider homosexuality as a medical problem. In reality, since its decriminalisation from military law, a no ask not tell policy has been adopted. Those who disclose their sexuality usually do so because they wish to leave the military. Likewise, sexually transmitted diseases are dealt with in the same way as in civvy street. It is only disclosed when it is a notifiable disease and sexual contacts are either told by the person involved or by the clinic. I would question the viability of your informants on these issues—perhaps you might like to go back to them and discuss it further." (Lauren Hurst is a nurse lecturer in the Royal Air Force working as Head of Nursing Studies at the Royal Defence Medical College, Gosport. U.K. He is a higher research degree student at Chichester Institute of
Higher Education working with Dr Gill Kester looking at role conflict experienced by military nurses in an operational environment. He is interested in medical ethics, and is currently doing research on the nurses and their view of war).

to be in.

What causes tension for the military doctor is the realisation that for the army system to work there must be some consistent discipline and this is sometimes achievable by taking drastic measures in case of deviation. The spirit in the army should be kept to a certain level and in a particular way "so that the machine can kill efficiently." For this to happen, training is important. Soldiers should have a certain attitude to life. One of the important aspects of military attitudes is that a soldier thinks of himself as part of a team. Efficiency means fitting well into the system even at the expense of self-interest or fairness. That is why the military doctor is torn between keeping the confidence of his patient (unfaithfulness to spouse or being gay for example) and protecting military discipline and practice, which seems to suppress the interest of the individual soldier in favour of the military system.[57]

A. Summers, as shown in footnote 57 below has pointed out that one of the duties of the doctors in the army was to deal with malingering. If a doctor in the army thinks that one of his patients is malingering, he would refuse to sign a sick note for him. Most probably the soldier would risk punishment if he insisted that he was not well. Here see that the doctor's position in relation to his patient is different in significant way. A civilian patient would simply go to another physician if he believed that his own physician was not being fair on him. This would not happen with a military doctor's patient who could face disciplinary measures.

In filling out medical certificates, military doctors pass on normally confidential details to the military authorities. The soldier's name, rank and number have to be filled in on the medical certificate, and more importantly, diagnosis. What this means is that the senior officers know an officer's private life. If for example the soldier were married, and, being away from their spouse, they contracted a sexually transmitted disease, the implication would be that they were unfaithful to their spouse and therefore it might turn out to be a disciplinary issue. By going to the doctor, a soldier or junior officer is risking a lot of exposure if they have something the authorities should not know about.

The other important thing that makes the military doctor different from his civilian counterpart is that he is not civilian. Military doctors have military training. According to my three military doctor informants, there is basic fitness training undergone by

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[57] See for example Appendix 4: "Restriction of Duties Medical Certificate." We can also find this tension way back in 1854 when predecessors of the present military doctor had to operate in the army. Why doctors were needed was that "in theory at least, the state could not afford an army of sick soldiers. Each regiment, therefore, had its own medical officer, who officiated at daily sick parades and attended the men in the regimental hospital. Malingering was as much the object of investigation as illness. For this reason, hospitalisation played a vital, and somewhat punitive, role in the army medical system. It was considered destructive of morale for sick soldiers to remain in barracks; hence the mildest illness or disability which prevented a man from carrying out his normal military duties was the occasion for his removal to hospital. (officers were of course, exempt from this regime of compulsion). If his disease or injury had not been contracted in the course of performing his duties, the bulk of a soldier's daily wage was deducted for the duration of his stay" (Summers, 1988:24).

Cantile (1974:500) also talks about the "black hole" meaning the army practice of disciplining a soldier by solitary confinement. One of the causes of illness for soldiers 21st December 1811 & 20th June 1814 was **punishment.** (Cantile, 1974:508).

I did not establish whether this occurred in present day armies. But it is not impossible. The tension then for the doctor is whether to continue treating the soldier if the soldier is injured. They also have difficulty if they have to decide whether one should get such punishment.

everybody including the doctors. The doctors are taught how to shoot and they carry pistols on military duty. The training is meant to make them into military officers. This training takes three months to complete. Peculiar to their programme is the course in military medicine. This includes training in treating gun shot wounds and different injuries specific to military caused illnesses. This is significant in that research into military arsenal and how certain chemicals can and cannot weaken the human body is carried out with the co-operation and assistance of military doctors. This is sometimes done with the specific intention of using the information to make weapons that can hurt the enemy soldiers and civilians if necessary. Medical research in the army may be useful for patients, but this is specifically and firstly the doctor's own patient-soldier, not a potential enemy patient, who may need to be treated in wartime.[58]

Another difference between a military doctor and a civilian one is that the former is not independent. He takes commands, just like other soldiers, from his senior officer, the most senior being the Surgeon General, a rank equivalent to a Lieutenant General. This is unique in that, obviously in the civilian world, the senior physician in the hospital or in a private practice does not issue commands the way that the army one does. He does not threaten punishment as the military doctor might. A senior medical officer in the army does not have the right to issue an immoral command, but all the same they issue commands that have to be obeyed by the junior in a way that is different from civilians. The threat of court marshal is more potent than any disciplinary measure that may be meted out by a civilian authority.

If military doctors are not really like civilian doctors, are they like other soldiers? They are certainly employees of the army. They have some basic military training. However their military training is basic, according to Colonel Lawrenson. It is not as thorough as that of other soldiers, for example, the infantry. But the training is good enough to enable them to defend themselves and their patients if necessary. It is good enough for competence with pistols. Military doctors do not carry out duties that are normally assigned other soldiers. For example, they do not carry out military manoeuvres. Military doctors do not normally engage enemy soldiers in combat. Their main function at the frontline, if they happen to be there, is first aid, resuscitation and other basic life support. Otherwise their place is in the first aid camp or at the hospital where they mostly work like civilian physicians.

So far it may look as if military doctors are doctors first and soldiers second. This impression may be changed if we look at the following facts: Firstly, other parts of the army seem to be professionally specialised and therefore called on to do specific duties not done by all members of the army. Secondly I argue that this specialisation does not make the professionalised soldiers any different from the other soldiers. Rather, they are part (and usually an essential one) of the army. Engineers for example are not likely to be sent to the frontline where engineering work is not urgently needed. Electricians who pursue their profession in the army would not be routinely posted to positions that have nothing to do with electricity. In peacetime, they are likely to work just like civilian electricians—carrying out duties related to electricity like repair and extension of

[58] The following Gulf war report makes this quite evident if it is true. It purports to have found out that top doctors are involved in research, and secondly that the Gulf war was "a lab, where we tested all the things we hadn't been able to test since Vietnam—and all the things they needed to test in order to maintain a war-fighting capability into the next century." (Sebastian, 1995:27)

available facilities. On the other hand, the infantry would be assigned duties that accord with an infantry soldier in peacetime as well as in war. They would be able to guard premises and properties and so on, in the normal course of events. In wartime the infantry are more likely to be sent to the frontline than electricians are, unless there is electrical work to be done.

When I asked my military doctor informants whether or not they followed the same procedures as other doctors in combat situations they pointed out that they did not. They do not plan battles for example. Their role is confined to manning first aid camps and hospitals. This may appear to show that they are in fact different from other soldiers until one attempts to answer the next question—whether military doctors carry out military strategies and planning or not. When asked, they say that they do not plan battles. But the important thing is that the military doctors have to fit into the military strategy and plan. If the aim is to inflict heavy casualties without incurring many losses, the military doctor has to be part of that plan. This is very crucial as it seems to make the military doctor different from their civilian counterpart and in a way comparable to a doctor involved in carrying out the death penalty because here we find the doctor being part of a plan to kill some people. It is clear that even enemy soldiers do not always have to pose an immediate threat to merit an attack, so that they are in a similar position to the death row prisoner.

Let us take a possible scenario, an example of a military plan in which the doctor has to fit. Let us suppose we have doctors, electricians, engineers, infantry and logistics. Our army has to attack a strategic position. The engineers have to provide a temporary bridge needed to cross a certain point. They have to estimate what is needed, how long it will take, and so on. The electricians would determine what to do with the lighting, which could hamper the project—where, when, and how to cut the supply and so on. The logistics experts would look at how the attack should be carried out, how many ground soldiers would be needed, their transport etc. The Surgeon General or a medical officer acting on his behalf/under him would plan the medical provisions related to the attack—given the use of certain weapons and tactics, the population and effect of the attack, a certain number of beds[59] would be needed in the immediate vicinity of the battlefront. The Surgeon General would also determine the medical specialists who would be needed. He has to account as well for the eventuality of such an attack as far as the troop's safety is concerned. They would estimate the needed medicine at various points of the planned action and how much collateral damage should be expected on both sides. If the plan takes some time before execution, it may be necessary constantly to monitor the health both mental and physical, of the soldiers and doctors involved. When they finally attack, the medical team would have to find out whether the troops

[59] This was raised by events in 1981 when "sixty physicians at Contra Costa Hospital in San Francisco refused a request from the Defense Department to pledge at least fifty civilian beds for the care of military casualties who would be airlifted from overseas in the event of a large-scale war. The Defense Department argued, in a letter sent to Contra Costa and other civilian hospitals across the country … that the extra civilian beds were necessary because 'a future large-scale conflict overseas could begin rapidly and produce casualties at a higher rate than any other war in history" (Bermel, 1988:302).
The Contra Costa hospital physicians argued that acceptance of the proposal would imply approval of the possible war. Whether they were right or not is not the main issue. It is important that they raised the question. One may see that the department of defence was well informed of the likely fallout and most probably it was an input from the military doctors. What is important in this case is that the medical professions were prepared to play a role in the calculated move to inflict death and disease in that war.

are combat ready. This may involve actual physical examination before they depart into battle, injections and ingestion of chemicals to protect against germ and biological weapons.[60] In short, the doctor consents to military operations just as his non-medical colleagues do.[61]

When I asked whether there is any conflict between the roles of soldier and doctor, two of my respondents said that there is no conflict. Colonel Baker, as pointed out above, thinks there is tension. However Colonel Lawrenson grants that whilst there is agreement that nobody may command a doctor to shoot when the doctor does not wish to, and that in war the military doctors understand that they have to treat all those in most need of medical attention irrespective of who they are (this means even enemy soldiers, who may get treatment before friendly soldiers if they are judged to be in more urgent need). There are other considerations that the military doctors have to take into account. Relations with other ranks are important. A friendly soldier is not just a potential patient of the doctor; he is a colleague—either his superior or junior in rank. As a colonel for example, the doctor has a collegial duty to other colonels of the army who are not doctors. He has to have the right attitude of junior officer to his senior and an almost paternal[62] one to the private, lance corporal and corporal—his juniors. All these things would weigh on the military doctor when he examines injured soldiers as they come in for medical treatment. It is therefore conceivable that the doctor may feel more comfortable in treating members of his own troops than the enemy soldiers. It is also morally demanding that an individual should be able to treat one who has been actively trying to kill either him or his own colleagues. This is the situation that may arise in the case of the military doctor in the battlefield.

It is also important to note that the military doctors are part of the current culture and would therefore be influenced by it. The attitudes, aspirations and beliefs of their day have an influence in the way they perceive their role in the army. For example, patriotism can be important. Historically, it has played a great part in medical care in the military. "The army nurses who went to Egypt in 1882 wanted more than the chance to

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[60] For example American soldiers appeared on CNN television taking injections prior to the start of the Gulf War.

[61] This is clearly demonstrated by Cantile (1974:1-2) who starts his book by pointing out how important doctors are for the army. According to him Colonel Walton wrongly suggested that doctors are not essential to the existence of an army. Cantile points out that "without doubt an army could exist without the Medical branch, but the question arises for how long? Walton wrote his book in 1909 and had he wished he would have found ample evidence to refute this irresponsible statement. Had he never heard of the disastrous Walcheren expedition when the campaign had to be abandoned due to malaria?…epidemics of yellow fever in the West Indies during the Napoleonic Wars when the drain on the lives of thousands of troops which were poured into these islands had a major effect upon the strategy of the war in Europe?…typhoid fever in South Africa, and cholera in India? It is true that until science had revealed their secrets in the second half of the nineteenth century the causation of many diseases was unknown and treatment was on an empirical basis, but even so did he really believe that without the Medical Department the results would have been equally successful? Armies would have melted away due to wastage from sickness unless hospitals had been provided to cure and return men to duty. And what of the moral aspect? History reveals that prompt medical aid for the wounded has a great psychological stimulus to the fighting spirit of combat troops.

Strong evidence in support of an efficient medical service was revealed in Burma during the Second World War when malaria would have wiped out the army within a few months had not special treatment hospitals been pushed up to the forward areas to cure cases and return them to the firing line. Many commanders in the field have had no doubts about the role the medical service has played in contributing to victory."

[62] Point made by Colonel Baker.

serve…. They wanted combatant status, and the normalisation of their right to war service. They wanted commissioned rank, and the salutes of the male orderlies." One would expect the nurses and doctors not normally to be interested in combatant status. But the culture of war itself has a lot to do with this desire because "for decades, war had been held up to women, as to men, as the most thrilling spectacle of the century, one which offered the most honourable prospects of public service" (Summers, 1988:175,198). This might still be the case in the present century. We still find many war veterans honoured today. The *Nursing Record***,** a nurses' publication in the nineteenth century, expressed its reservation about war. But:

> these dissenting opinions, however, seem not to have been representative of the majority of nurses. None appear to have seen the retention and expansion of the British Empire as anything but desirable in itself. More than this, nurses accepted the definition of the empire as the public arena in which they themselves should seek distinction. They not only supported every measure promoted to strengthen and protect the empire, but demanded equal rights with men to participate in these measures (Summers, 1988:200).

We have no reason to suppose that doctors are in the same position today, but it is likely that they have their personal preferences as far as national affairs are concerned.

One may suspect that practically the military doctors may routinely give preferential treatment to their own colleagues in the army as compared to the enemy soldiers. One of the reasons is that soldiers have a moral right to expect treatment from their own doctors, and they would rightly demand to come before enemy soldiers if they needed treatment because the army doctor is primarily there for their benefit, and not for the benefit of enemy soldiers. The saving of enemy soldiers is important only if it is a strategic move to get information for example that would otherwise be unavailable. It is therefore understandable that when two soldiers who are equally injured come into the treatment room, the doctor is morally required to treat his own before the enemy soldier. This arises from the fact that soldiers' health was entrusted to the doctor by the army. He is a military doctor because the army needs his services. He is contracted to the army—that his duty is to protect the soldiers and as a soldier himself, to protect the state against its enemies. For the military doctor to choose enemy soldiers' health rather than his own soldiers' simply because they are human beings seems to go against the idea of waging a war. If the army is prepared to kill enemy soldiers including innocent people in a war, it would be odd to expend resources meant for the army on enemy soldiers.

There is also what has come to be known as the "MASH phenomenon,"[63] which seems to prima facie, raise moral problems for the military doctor, and, I suggest, may be analogous to doctors treating prisoners in preparation for execution. The phenomenon is a reflection of some cases where in a war situation military doctors treat soldiers who are injured in a war only for the soldiers to return to the battlefront and get possibly injured or killed. A situation can be imagined when sending soldiers to a particular battlefront is as good as sending them into the gas chamber. The idea is that, is this behaviour by doctors not analogous to the doctors treating death row prisoners in preparation for execution? The doctors repair the prisoners only to have them killed afterwards.

One may object that the analogy does not fit properly. In the case of soldiers at war the military establishment does not send soldiers in order for them to be killed. They

[63] Tom Sorell called this to my attention in 1999.

send them to defend the country. Having soldiers killed is one of the things that the army specifically tries to avoid. In short, the preservation of army personnel is one of the primary goals of waging a war at least from a military point of view. This is obviously not the case with an institution that practices capital punishment. This objection might hold in some cases. But consider a situation where the army knows that the risk of being killed is very high, how would sending the previously injured back to battle be justified? It seems to be clear that the intentions in the cases of capital punishment and war are different. The problem is that the results are similar—in both cases the patients get killed, and their deaths are foreseen. This is important and therefore suggests an analogy between the medical treatment of prisoners in preparation for execution and the medical treatment of soldiers before going to a dangerous battlefront.

Asked whether there is a conflict between the military doctor role and medical ethics my informants said there was none. They went on to say that medical ethics was primary in case of a conflict, presumably meaning that they would follow the demands of medical ethics rather than those of the army. But we have already seen that this is not the case. Medical ethics seems to hold doctor-patient confidentiality to be one of its most important tenets. The agreement to tell the military institution about one's patient—whether they drank too much, or whether they are homosexual, for example, is suggestive of an apparent violation of the fundamental tenets of medical ethics. Here we find that other considerations besides the interest of the patient take a prominent position in the mind of the military doctor. Issues such as troop morale and safety, consistency and obedience to commands seem to become important in the thinking of the military doctor along side their patient's interest. This would appear to challenge the claim that medical ethics is primary for military doctors.[64]

Military doctors can only be promoted to the rank of Surgeon General (equivalent to Lieutenant General). The military doctor may not continue practising medicine and become a soldier of higher rank because the medical profession itself limits such a development. The military doctor would have to give up medicine if he wanted to

[64] It is quite clear that Amnesty International and the medical associations of the world are against torture. The fact that there is realisation of the added danger of medical involvement in torture by medical doctors working for the army, police or prison service seems to suggest to me, that the same wariness should be shown on the possibility of the involvement of the violation of medical ethics in the army. The fact that medical doctors are involved in torture does not necessarily mean doctors should not be involved in prisons and armies, but it is enough reason for one to begin questioning that involvement. The same is true of medical involvement in war and armies. Consider for example the number of incidents of torture and extralegal killings reported throughout the world in the last few decades. "The case of those Israeli medical doctors … who serve in the prisons where interrogation and torture of Palestinians take place daily. Each such prison has at least one doctor in service at all hours. His role is to examine beaten prisoners and to see if they can continue to be tortured; and at times his role is to heal them to a level of health that will allow the torture to continue" (Gordon, 1995:18).
In the same volume Hernan Reyes (1995:41-42) argues that physicians working as part of the police or armed forces often have a conflict. "This is especially true in war or internal strife situations. … For reasons that cannot be merely ignored, security personnel prefer working with physicians whom they consider to be part of the security system."
Amnesty International Medical Commission and Valerie Marange: (1991) have looked at the involvement of doctors in torture and capital punishment.
Brazil and Chile were used as examples where doctors could have been involved in the torture and killing of some people that were dealt with by the ruling army. Crelinsten, & Schmidt (eds) (1993).

become a career soldier in that sense. One might think that this suggests a peculiarity of the medical profession in the army. It is not the case. The reason is that the military doctor does not have enough military training to be in charge of a bigger section of soldiers beyond the rank of Surgeon General. If the Surgeon General aspired to be supreme commander of the army for example, he would have to undergo further military training. There is no bar to the Surgeon General's doing this. So a military doctor could in theory be in charge of planning to attack or presiding over such plans and therefore directly responsible for giving commands to kill people if they got promoted to the higher post. Once we accept that bombing a crowded city is at least apparently against saving lives we would appreciate that by commanding, directing soldiers to plan to or bomb a city, the military doctor commander is acting against the aims of medicine which are to save lives even those of enemy soldiers.

Is the military doctor role morally justified? This is an important question but I do not intend to dwell too much on it as that might lead to a digression from my main topic in this chapter. An indication of a possible answer however is in order. There are two arguments that may be advanced in favour of the role. The first is from self-defence—a country has the moral right to defend itself by building an army. This of course raises problems for the pacifists. If a country has the right to build and maintain an army as a means of self-defence, and keeping the troops healthy is integral to that goal, then it would at least prima facie appear to be morally right for that country either to provide its military with medical training or employ medically trained personnel in its army.

All citizens need a country secure from attack by external enemies. Everyone, including the medical profession, has an interest in the existence of armies, if they keep countries secure. I believe that it is the case that some armies do bring security to their countries.

Individual medical professionals do not cease to be citizens when they take up the profession. This means that as individual citizens they may have the same right and duties to the state as other citizens including the duty to help in the protection and defence of their country. So they may make their contribution by being soldiers, and military doctors in particular.[65]

The first point to note about the moral importance of doctors' involvement in the army is the apparent contradiction or at least tension between what the two roles—military, medical—entail. Whilst the medical role stands for the saving of human life, the military one stands for killing if necessary. If this is the case, or if it is possible, one may ask why the medical associations and Amnesty International do not object to the

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[65] The other argument for the existence of the military doctor role is that the main goal of medicine is to tend to the sick and injured and people in military situations are especially vulnerable to injury. This is well expressed by Lauren Hurst who argues that: "most certainly it would be immoral to go to war without any health care at all. One might also suggest that removing health care support will not stop war, as the caring would be taken over by combat med techs/med assists—harking back to the days of the knights, when they engaged in war during the day and cared for the injured after the battle was over. Certainly, health care for the troops is a morale booster, they need to know that if they get injured they will be cared for. This is also more important now because of the role of the media in war—immediacy brings the war into our front rooms. There would be a public outcry if soldiers were not treated and left to die. Certainly, from my study it is becoming quite apparent that the nurses view their role to be important and one that is integral with nursing. For their roots lie in the history of the military. They do not perceive there to be any role conflict, rather it is role tension juggling nurse and warrior in an attempt to gain balance." Appendix 2: Hurst, personal correspondence, p.1.

existence of the military doctor role[66] just as they protest against the medicalisation of capital punishment. At one level, if one grants that being a soldier involves and includes killing people, doctors should not be soldiers because it would involve them in killing people. The fact that the medical association and Amnesty International do not object to the military doctor role seems to suggest that the medical role actually goes beyond life-saving[67] or that Amnesty International and medical associations have not thought about the issue.

We can begin by acknowledging that soldiers are there primarily for self-defence and every country has the right to self-defence. So the existence of an army can be justified on that account. But unlike the police and other state agencies, the army protects the state by being willing to kill people who may be soldiers and civilians. This is because the only time that an officer acts peculiarly as a soldier is when he is engaged in war. This includes training for war. And it is in the context of war that an army doctor can function fully and peculiarly as an army doctor.

It is important to note that having an army is a way of preparing for war. So even if most of the time soldiers are not involved in killing people, their work involves planning how best to do it and the readiness to do so as efficiently and quickly as practicable. There is an element of readiness and intent to kill including as said above, non-combatants. Soldiers are trained to kill, and the military doctors help them in a war situation to achieve it.

Murray has pointed out why doctors should not be involved in planning for war. He grants that when people—soldiers and civilians—are injured, the doctor has to treat them because not to would be a violation of the medical vow to treat patients. He argues:

> what of those who are not the physician's patients, who, if physicians act effectively now, may be spared this manmade encounter with illness or death? Surely a physician's dedication to health is not limited to repair—after illness or calamity has struck. Just as the physician should instruct patients how to live a life as free from future illness as possible, so the physician should bear some responsibility toward others; if not affirmatively seeking them out and helping them, then at least using his or her powers—medical, political, or otherwise—to assure that their well-being is not risked frivolously (Murray, 1988:308).

Murray goes on to say that doctors as people responsible for the protection of society's health must have views about war. That is, they must know the score. They are experts in detecting the causes of illness and therefore society relies on them for that together with ways of improving health. They are better placed to focus on issues that are pertinent to health. War seems to be the kind of activity that, to say the least, jeopardises the health not only of enemy soldiers and their civilians, but that of friendly soldiers including doctors and their patients. So other things being equal, they should

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[66] When I sent e-mail to Amnesty International Ethics department to find out what they think about the morality of the military doctor role they did not have a policy, but it seems to be safe to assume that they accept the military doctor role. It seems to be the case that soldiers' work is to kill. The army doctor helps in that work. This seems to be contrary to the vow to protect human life. The army doctor also seems to violate other ethical prohibitions like confidentiality. Besides medical duties, the army doctor has others like the protection of soldiers who are not necessarily his patients against those who are. It would appear to call for the same attitude from Amnesty International and the medical associations. See Appendix 3.

[67] In 1981 when the American Defence Department wanted to prepare for war with the co-operation of civilian hospitals the American Medical Association agreed (Bermel, 1988:302).

not assist or allow war to happen. This is not my position, but one would expect those against the medicalisation of capital punishment on the basis that it is against medical ethics to argue along these lines.

There is a way in which war is different from capital punishment medicalisation. Whereas in the latter there is a direct link with the death of the prisoner, it is not the case with the former. There is a distance between the death of a person in war and the doctor—the doctors do not do the killing—whereas capital punishment medicalisation requires the direct link—the doctor has to kill the prisoner—between the doctor and the victim. On the other hand, military doctors contribute to a war effort. The military doctor's role in war is of such importance that without it war preparation and preparedness would be different. The important contribution to the war effort by the military doctor is that he ensures the health of those who would kill people in a war. Whereas medicalisation may certify the prisoner to be fit for execution, the military doctor certifies the soldier to be fit for killing, at least potentially, in a war. Whilst one ensures the fitness of the victim, the other ensures the fitness of the one who participates in a process that may result in killing.

What all these show is that the doctor in both cases has got obligations not necessarily to a patient or patients, but to the state. There is no doubt as to the definite and vital contribution by military doctors to war. For example, Brand shows how doctors have been important in war efforts of the British forces. Doctors had to select healthy men for recruitment to the army and they had to maintain the health of soldiers engaged in war (Brand, 1965:138,140). The fact that in the battle field, a military doctor prepares the soldier both physically (the doctor ensures that they are not ill) and mentally (the doctor may have to provide counselling for the soldiers and assure them that everything is alright or will be) to risk being killed, and go to kill enemy soldiers and civilians at times, seems to be analogous to capital punishment medicalisation where a doctor ensures the fitness of a condemned prisoner. In neither case does the doctor kill the victim, but he helps in the process of the victim getting killed. If there is something morally wrong with capital punishment medicalisation surely there must be the same with the military doctor role here.

Is there an analogy between medical involvement in the army and medical involvement in capital punishment? One can look at the justification of both capital punishment and the military—is the military doctor role justifiable and is capital punishment justifiable? Sorell and others would argue that in some cases capital punishment is justifiable (Sorell, 1987). But then if capital punishment is justifiable in some cases, it does not necessarily mean medical involvement in it is justified. In fact, the World Medical Association and others have not objected to medical involvement in capital punishment. They however object to its medicalisation irrespective of the moral status of capital punishment. The same argument can be advanced in the case of medical involvement in the army. Sometimes it may be morally justified for countries to have armies (self-defence) and at times the armies may be justified in having military doctors, but does that make it just to involve doctors in war? I am inclined to think that if capital punishment medicalisation is morally wrong, medical involvement in war should not be allowed because, just like capital punishment medicalisation, medical involvement in war would mean doctors contributing either directly or indirectly, to the killing of people.

The two are not the same, because, according to the Amnesty International ethics department:[68]

> The doctor assisting in an execution is working for the state with the objective of extinguishing life. The condemned prisoner has no power, is not at that time a threat, and may or may not have been well served by justice.
>
> In a war, the conflict is between military forces within which doctors are (theoretically) able to play a life-preserving, rather than life-taking role (as in the death-penalty). Doctors who fail to focus on life-preservation or healing (by, for example, undertaking military tasks) risk losing their protection under the Geneva Conventions and could be in other sorts of ethical trouble.

In other words, while the capital punishment doctor is working for the state with the objective of extinguishing life, it is not the case with the doctor in the army. My contention is that it may be true that a military doctor in the war zone may be "working for the state with the objective of extinguishing life," at most; the doctor belongs to an organisation with that objective. The government and the army may have as an objective, to kill enemy soldiers and at times, civilians. Many targets of the armies may not necessarily have the power to do any harm to them (their enemy forces). For example soldiers in their barracks do not necessarily pose immediate danger to their attackers and yet they are deemed to be legitimate targets. Soldiers do not necessarily pose danger to their attackers especially when the attackers take a supposed pre-emptive strike.

There is also a problem with Amnesty International's suggestion that a military doctor in the front-line is there to preserve life. A doctor in the battlefront saves life but not necessarily that of all people endangered by the war effort. Let us imagine for example a situation where a group of commandos are caught by enemy fire and they sustain injuries. When they get back to camp the doctor treats them and after a week they are war-ready. In fact thanks to the doctor's intervention, one of the soldiers could have died from the secondary infection of his bullet wounds,[69] and he happened to be the most important member of the group. Suppose the commandos were shot whilst on a spying mission, in fact, on their way back to base. They had gathered all the necessary intelligence for mounting a major offensive—bombardment of an important industrial city that manufactures among other things, tanks and military vehicles. After their recovery they carry out the mission as planned with maximum efficiency—a few thousand are killed, soldiers and mostly civilians. At the planning stage of the attack, the military doctor's input was to predict that the collateral damage would be a few thousand. He also put a plan in place to treat the commandos should they be injured. He also provided the necessary counselling service should it be needed in the immediate aftermath of the raid. In this case we would agree that the doctor saved life, but that is

[68]Appendix 3. Amnesty International "ethics of medical participation in war questionnaire." I contacted Amnesty International ethics department to find out what they think about the morality of the military doctor role. I also wanted to find out whether there could be an analogy between capital punishment medicalisation and medical involvement in war. It appears many of the questions I raised were not covered by any policy of the organisation.

[69] Soldiers can be in more danger of disease than enemy fire. This is what is supposed to have happened to the British forces when during the Boer War of South Africa "only 22,000 were treated for injuries and accidents in the 30-month struggle, but some 74,000 were struck down by preventable fever and dysentery" (Brand, 1965:140).

not the whole story. His saving life led in a very direct way, to the devastation of a city and the accompanying collateral damage. This in short shows that the military doctor saves the lives firstly of his own side.

Another situation can be imagined where a doctor in the battlefront is caring for the injured thereby carrying out his life-saving role. When enemy soldiers arrive at the camp and try to capture him and his patients, the military doctor may shoot and kill them in his own defence and that of his patients. If and when he does, he has not only saved the lives of his patients, but killed other people as well. So the duties of a doctor in the battle field may include guarding the camp and having to kill enemy soldiers in which case it would not be accurate to say that the doctor's role in war is a life-saving one.

To deal with the argument that there is an analogy between the medicalisation of capital punishment and the military, let us look closely at what the military doctor does. The first thing to note is that the military doctor role resulted from necessity. It was upon realising that on their mission to defend the state (by killing when necessary), soldiers got exposed to two types of danger—disease and artillery from both friendly and enemy soldiers. Nowadays it is even more necessary to have doctors in the army since the dangers have been increased by the possible use of biochemical weapons. Technology and genetic studies have taken developments to a level that has bearings on the way wars are to be fought. All these open up huge potentials and chilling possibilities as the military doctor can be involved in research to reverse the effects of biochemical weapons and also in some way be involved in their manufacture.[70]

In Britain, medical doctors do not have a role only in the army. They are involved in many branches of the defence system. There are medical personnel in the air force and navy. All medical personnel in the armed forces belong to the Royal Army Medical Corps. These medical personnel include doctors, nurses, paramedics and medical assistants. One may safely assume that the military academia and research facilities have medical branches that are involved or engaged in research that is especially of military significance. It is highly probable that the direction and content of such research and personnel would be of a highly sensitive nature and therefore belong to the state top-secret category.[71] The report on the Gulf War referred to in footnote 70 shows the possibility of doctors' involvement. It claims that in Texas secret research is going on that involves doctors and it is related to chemical weapons.

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[70] Doctors may be key to bioterrorism

ARLINGTON, Va. (AP) - It will fall to doctors - not the military or police - to recognize when bioterrorists have struck and to react in time to stop thousands of Americans from getting sick or dying, experts told the first medical conference on the danger Tuesday. Imagine a truck driving by a football stadium during a fall game. It sprays a mist that drifts over the stadium. Nobody notices. Two days later, hundreds show up with sniffles and fevers that doctors believe is the flu. But five days later 300 people are dead before a local scientist solves the mystery: It's not flu, it's anthrax. Johns Hopkins University used that fictional scenario to tell doctors the danger is real - and the nation isn't yet ready to handle it. See http://www.infobeat.com/stories/cgi/story.cgi?id=2558478693-186

[71] For example it was reported that both the American and British governments were economical with the truth regarding a mysterious illness suffered by the Gulf War veterans. It is alleged that for example "many details of the Gulf war have been obscured on the grounds of national security. Even going back to the Second World War we discovered that chemical weapon tests remain classified, **with participants sworn to secrecy. For 50 years the blanket official silence has prevented treatment and care for sick people and is still in place"** (*emphasis added*) (Sebastian, 1995:23).

I have argued that the military doctor is more like a soldier rather than a civilian doctor. Medical involvement in war and the army is comparable to medical involvement in capital punishment and therefore calls for opposition from those against the medicalisation of capital punishment. This stems from the peculiar nature of the military doctor role. Given the above, there seems to be a case for either the medicalisation of capital punishment if it is morally justified, or the non-medicalisation of the military if it is not morally justified. These are the options left the likes of medical associations who argue for the non-medicalisation of capital punishment and yet accept the medicalisation of the military.

How is the tension in the role of military doctor to be resolved? There are two issues here: the insulation of doctors against killing on the one hand and the demands of duty, justice and citizen responsibilities on the other. I contend that the duty of doctors to behave in a way that is consistent with medical ethics sometimes has to give way when performing that duty conflicts with the duties of other morally important roles. This could be the reason why not so many people seem to be morally troubled by the military doctor role as they are by the medicalisation of capital punishment.

If the military doctor can permissibly kill in a war situation, as I have suggested above, what could it mean for the medicalisation of capital punishment? Since few people if any have raised an objection to the military doctor role, it may be a good idea to think twice about whether the doctor-executioner role is really coherent if it is like the military doctor role. This is what I am going to discuss in the next chapter.[72]

[72] There is an appendix to this chapter in which I give an example of medically justified killing which shows that the medical role does not necessarily require the protection of life.

CHAPTER 5

MEDICAL INVOLVEMENT IN THE WIDER CAPITAL PUNISHMENT PROCESS

I now turn directly to the question of medical involvement in capital punishment. Medical doctors are involved in different stages of the capital punishment process. Some of the stages are acceptable to the medical associations and others are not. My argument is that some of these acceptable stages of involvement are analogous to the unacceptable ones.

I will distinguish between different stages of the capital punishment process and argue for the justifiability of medical involvement at those stages. I suggest that capital punishment seems to be comparable to war. Both involve justifiable killing and they raise the possibility of medical involvement for similar reasons. I also argue that medical doctors have obligations not just to their patients, but to the state as well. These obligations are not necessarily of a therapeutic nature.

As I have stated in Chapter One, medical involvement in the capital punishment process begins at the investigation stage when psychiatrists may help with a psychological profile of a murder. Forensic specialists can be called upon to help with information that may determine the identity of a suspect—they may identify forensic material that can be used to tie a suspect to the crime scene such as hairs and sperm in the case of rape related murders. Physicians—gynaecologists can help in determining the physical nature of the attack on a rape-murder victim (the same evidence can be used at the trial stage).

Once the suspect has been arrested and the necessary legal procedures completed, the suspect would be examined as to whether he is competent to stand trial and plead. A competent medical professional does this. The medical involvement stages which follow are: relevant medical evidence during trial; aggravating or mitigating circumstances at the sentencing stage of a murder trial; prisoner care (medical attention—psychiatrists and physicians) while on death row; clinical assessment of prisoner's competence to be executed; physician examination of prisoner in preparation for execution; treatment to restore competency to be executed when found to be mentally incompetent or physically unfit; prescription of drugs to be used in the case of lethal injection; determination of the voltage to be used in the case of electrocution; measuring and weighing the prisoner, determining the drop and length of rope in preparation for hanging; giving technical advice as to the maintenance and efficiency of execution instruments; consulting with and supervising execution staff; administering and prescribing tranquillisers before and during the execution; subduing the prisoner by medical means when he refuses to co-operate with the executioners; selecting injection sites; starting lethal injection devices; monitoring the execution; attending, observing

and witnessing an execution in a medical capacity; determining death; certifying death and soliciting or harvesting organs for donation.

It is helpful to set aside the type of medical involvement that raises moral difficulties at this point. In general it would seem that the earlier stages in the capital punishment process are less problematic than those immediately surrounding execution. Forensic evidence, certification that the prisoner is fit to stand trial, medical testimony during the trial and pre-sentence evaluations seem to raise less moral problems for a lot of people than the other stages. I suggest that they are not very important, but I will still make use of them. Electrocution, lethal gas, hanging and firing squad are different from lethal injection and they do not specifically demand medical involvement in the sense that lethal injection does. For that reason I will assume that participation prior to execution by these methods is more or less similar to what I will deal with under hanging. Medical participation in the actual execution itself by these methods is not a medical function and therefore can be done if it has to be, by professionals other than medical personnel. I will therefore not discuss these. Evaluation for execution fitness and treatment to restore it seem to be the most important as they are more directly linked to the execution itself. I will follow medical involvement at different stages from the beginning leading up to the execution. This means the more morally important stages will be dealt with later on. I will then justify involvement at different stages by analogy and comparison to other medical involvement. But first I will consider a different justification for medical involvement in capital punishment.

INSTITUTIONAL JUSTIFICATION

I have already suggested that in accordance with Gewirth, institutions may be justified on the grounds that they protect moral rights. Let us take law for example. If we grant that it is by means of laws that people's interests and wellbeing can be protected, we have to accept that the principle of rule of law is morally important. In the case of capital punishment, if the law providing for the process of trial and execution were justifiable, it would appear that the related institutions should not be opposed by medicine. This is how we come to that conclusion. The pursuit of interest and wellbeing of people is justifiable as long as that does not violate any moral right. This means that institutions can be formed in pursuit of this goal—the legal institutions/justice system. These justified institutions can attain their goals by means of roles that they create. In this case, the legal institution creates the role of medical witness. This is important for justice. For example if it is unjust to execute an insane person, and justice is consistent with the pursuit of people's interest and wellbeing, it would be proper in a morally important way, to restore sanity before execution. Because this can only be done through medical involvement, it would be necessary to have a medical role in the process. This means medicalisation is justifiable if the legal processes it assists are morally justifiable.

There could be justifiable involvement of medical doctors at different stages of the process of execution and in other matters. Involvement that is acceptable as distinguished from what we called "medicalisation" in chapter one may involve forensic investigation in a capital trial, certifying the competence of a suspect to stand trial,

giving evidence for the prosecution in a capital trial and doing the same at the sentencing stage of a capital trial even against the defendant. These forms of medical involvement are presumably ordinary medical practices comparable in a morally significant manner to, and just as justifiable as, a doctor dispensing medical benefits to patients in a hospital or clinic.

Now let us turn to those other issues that appear to raise only minor moral problems and that are acceptable to the medical associations. How does their acceptance impact upon the understanding of the other stages of the capital punishment process?

MEDICAL INVOLVEMENT AT THE INVESTIGATION STAGE OF A CAPITAL CRIME

To begin with the forensic doctor, I believe that his work is different when he gives forensic information to a police investigation team into a murder from when he gives similar information to his medical colleagues who are researching the clinical implications of that information. The former does not yield an actual or potential therapeutic result, while the latter does. It is true that in both cases the forensic medical doctor would have given the information in his capacity as a doctor. The important difference between a doctor acting in the first case and the second is that the murder investigation is the beginning of a process that may lead to the death of a human being (the defendant if subsequently found guilty). This process clearly does not have any therapeutic benefits to the defendant. This is different from the other case that does not directly link to a process that may result in the death of a human being, and might result in therapeutic benefits to those subjected to the procedure. A doctor who takes blood samples from a suspect acts in a significantly different manner from one who does so that the person providing the samples, or someone else, may be treated. In the latter case, someone benefits therapeutically, whilst in the former case no-one does. What this means is that in the cases where the doctors' activities do not result in therapeutic benefit to the subject, the doctor would just be making use of his medical skill for something other than therapy. Once this is granted, the morally important question is which non-therapeutic medical activities should be morally allowed, and why. Thus since the forensic medical doctor can sometimes carryout non-therapeutic activities like helping the police without moral problem, they can do other things besides medicine with their medical knowledge.[73]

What is of particular importance here is that when the medical doctor assists in the investigation of crime, he is participating in a process that protects moral rights. This is morally justified irrespective of what the crime is. The moral justification of criminal investigation is the fact that legal institutions, of which criminal investigation is part of, are not just among morally permissible institutions—they are arguably basic—because

[73] The question may be raised here as to whether forensic doctors are doing something other than medical or what the above shows is that some kinds of medicine are non-therapeutic. To identify some blood as belonging to group A for example is not in itself therapeutic, but that information is usually for the benefits of patients in say, blood transfusions. The police can use that same information to identify a suspect. If a suspect has blood group A and the blood found at the crime scene for example is group O, it would mean the suspect could be freed by the doctor's testimony.

they make moral rights their main business. So the procedure of gathering evidence as a basis to establish guilt by due process in a court of law, justifies forensic medical involvement.

MEDICAL INVOLVEMENT IN OTHER NON-THERAPEUTIC ACTIVITIES

It is very difficult to come up with medical behaviour that is comparable to medical involvement in the investigation and trial that lead to execution. But there are cases where doctors are involved not necessarily for immediate therapeutic benefit of those they examine—subject/patient. The examples are medical examinations required for jobs, insurance claims and immigration. In all these cases, as in the medical involvement in capital trials, the results are not necessarily for the benefit of the subject. For example, an insurance claim may be lost because a medical examination revealed that the claimant was drunk in the case of a motorcar accident. A medical examination may reveal that a candidate for a particular job suffers from some illness or a student applicant may not get admission into a course of studies because of his ill health. This can also happen in the case of an immigrant who may not be allowed entry into a foreign country when he suffers from some kind of disease. So in these cases the work of the doctor does not necessarily favour the subject/patient. But there are two important differences between medical involvement in capital crime investigation and these other cases. The suspect does not generally want to give samples for investigation: he is usually compelled or pressurised. He might be misled into thinking that some benefit might accrue from the examination, for example that there might be stronger suspicion that he committed the crime if he refused. When a doctor collects evidence for the prosecution in a capital case, on the other hand, the intention of the activity is specifically to get the prisoner executed if found guilty.[74] This is different from all those other cases where a prospective employee understands that it is in his interest to have a medical examination to certify that he is fit for work. The subject/patient therefore consents to the doctor's activity with the understanding that it is in his interest. This is evident because when it is discovered that the candidate has some illness he usually gets treatment whenever it is possible. The intention of the medical examination in this case is never meant to be against the subject's interest even if it can be the case that the corporation or employer demands the medical certificate to protect itself. The same can be said about immigration where the traveller could go back to his home, get treated and emigrate when healthy. This should be enough to suggest that the medical role in the investigation and trial of a capital case is not comparable to other medical roles. They are not to the benefit of the patient.

One can surmise from the above conclusion that for the medical professions to accept this kind of involvement they probably must be justifying it differently in jobs

[74] There is an alternative explanation of medical involvement here, which is that the intention might be to find whoever is guilty of the crime—whatever the punishment. This would not invalidate the argument that the prisoner does not necessarily have medical benefits as a result, especially when such involvement would show that he is guilty of the crime. Medical involvement here could also be justifiable on the basis that it promotes fairness—if the evidence helps to establish guilt, it may do so in a fairer way than if medical information was lacking.

such as insurance, education and immigration. If the level and type of medical participation discussed above is permissible, we might find that medical participation in other stages of execution, if comparable, should be equally permissible.

MEDICAL EVIDENCE THAT THE SUSPECT IS FIT FOR A CAPITAL OFFENCE TRIAL

If there is something morally wrong with medical doctors contributing to the execution of convicted murderers, I would suggest that the listed activities of doctors in the process that finally results in the execution of a convicted murderer needs closer examination beginning with those supposedly morally acceptable ones. Concerning a capital case where a medical doctor certifies that the suspect is fit to stand trial, his behaviour is morally different from ordinary medical practice. Contrast this with the doctor certifying that the subject is fit to undergo a certain medical procedure. The process of examining the subject and so on, in the two cases may be the same. The doctor makes use of medical techniques in both cases. The difference is in the intention, or role (standard medical role versus non-standard medical role). On the one case the doctor makes use of the medical know-how so that the subject may be held for questioning and probably punished ultimately whereas the other one is done so that the patient may receive medical treatment. From a medical/therapeutic point of view the subject who is a suspect does not benefit and there is no intention to benefit him whereas the other one does and treatment is geared toward such benefit.[75] This is a morally significant difference. In the case of a suspect subject, the doctor knows that if found guilty the subject would probably be executed. Contrast this with the other case where the doctor knows that his activity can only be for the benefit of his subject if the operation succeeds. If it does not succeed, we cannot say that the doctor was either indifferent to or agreed with the outcome of his activity unless he did not want to behave as doctors do.

One would not have reasonable grounds to argue that such medical involvement is morally unjustifiable. In the case of a medical doctor determining that a suspect is fit for a capital trial, the doctor's involvement is not justified by a patient-physician relationship. It is rather based on the needs of the justice system—that the moral rights of the accused are respected—he should not be tried if he is insane for example, which would be a violation of his moral rights. The moral right not to be subjected to criminal proceedings when one is insane, seems to be important, and might be as important as the moral right to be medically examined to determine that one is fit to undergo a medical operation. Both of these types of medical involvement seem to be for the promotion of the concerned individuals' interest and well being, and, of course, probably that of others as well.

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[75] There is obviously a way in which the suspect may benefit. For example if he is not responsible for the crime, the doctor's evidence may help the police to release him earlier than they would if there was no information provided by the doctor. This is a benefit that is different from medical benefits. Not being held in a cell is of medical benefit if at all, in a general way in the sense that the subject may not suffer psychological conditions such as stress and anxiety. This is less related to the medical/therapeutic benefits and it is comparable to the information that can be given by a friend who provides an alibi which also means the suspect will not suffer stress and anxiety as a result of being held in a police cell.

MEDICAL TESTIMONY IN A CAPITAL TRIAL

When getting information from a subject and later providing different people with it, the doctor defines his role. Sometimes the information is used for the medical benefit of either the patient/subject or some other people. But sometimes it is not medically beneficial to the subject or any other person. Testifying as a medical expert in a capital trial is an example of the doctor providing information about the subject that is neither for the medical benefit of the subject nor the medical benefit of other people. Contrast this with giving the same information to a medical research team or a ward doctor who takes care of the subject. At this point one can say that at least the doctor is neutral about the therapeutic value of his testimony to his subject when he stands against him in court. When this is contrasted with cases where the doctor gives the same information for therapeutic purposes there might not be that much of a moral difference between his two activities. But that is not all. By testifying against the subject the doctor sets himself on a course that is not neutral to medical values, but in opposition to them. Whilst the doctor may be understood to be saying in the case of providing information of therapeutic value, that he stands for the benefits of his subject, in the case of testifying against a subject in a capital trial, the doctor says that he is prepared to help the people who are actively devising means to harm the subject by execution once found guilty.

Should medical doctors give medical testimony in a capital trial for the prosecution even if there is risk of the defendant being found guilty and subsequently executed—is that morally justifiable even if it is not a therapeutic role? They should. What is becoming evident is that doctors have non-therapeutic roles that are justifiable. These roles make doctors to be not just morally obligated to care for their patients, but the performance of those other roles as well. For example, they are the obligation to be committed to justice, which governments promote through the judicial processes. This means some of the roles taken by the medical doctors are not only non-therapeutic, but they can be anti-therapeutic—like helping in the conviction of a criminal may lead to medical problems for the prisoner—psychological and physical illness.

PRE-SENTENCE MEDICAL EVALUATION

Psychiatrists are sometimes called to testify at the sentencing stage of a capital trial on behalf of the prosecution, when the prosecution argues that the defendant must be executed. For example, the psychiatrist may be asked whether the defendant in his opinion is sorry about what he had done or not, and whether he poses a grave danger to society. By testifying in this way, the doctor is at a point in a course that ultimately ends with the death of his subject—if he gets executed. The intention of the prosecution which seeks execution in a capital case are clearly against the subject and are in no way positively relevant to or supportive of his well being. By aligning him or herself to such a prosecution side, the doctor is just making use of his or her medical knowledge for something else that is incompatible with his duty of beneficence.

Medical testimony at the sentencing stage might also be unacceptable on the grounds that behaviour that aids governments to execute people is in violation of the medical principle of nonmaleficence (Bonnie, 1990:12). This raises the question as to whether or not pre-sentencing evaluations are comparable to any other activity that

doctors may be engaged in. There seem to be situations in which doctors are involved that might be against the doctrine of nonmaleficence. A clear example is their involvement in forensic evidence, which even though does not bring about the execution of the prisoner, helps to secure his conviction that may lead to his death. A suspect can be sentenced to ten years of hardship in prison and he may take it to be worse than death itself. In that case the doctor would have helped bring about something that is not in the interest of the prisoner.[76] As Bonnie points out, this by itself is not taken to be a violation of nonmaleficence. On the other hand if a life sentence could lead to living conditions that are worse than death, it appears to be the case that compared to forensic medical involvement in execution, it is not necessarily morally worse.

One might object and say that the use of maleficence is beside the point because the doctor is acting in role of officer of court versus the defendant—not as someone who treats patients. What is important here is that the doctor has taken up a role that may put him in a position, which demands that he risk harming the defendant—if incarceration and punishment are harms to the prisoner. This is at least not consistent with the doctrine of non-maleficence, which is that doctors should do no harm.[77]

MEDICAL EVALUATION OF FITNESS FOR EXECUTION

The evaluation of the prisoner's fitness for execution raises the question whether it is proper for a medical doctor to recommend that somebody should be killed. The problem is that there is no medical condition "fitness to be executed" which the physician can diagnose. If medicine has a life saving role in society, then here it appears to be against it. How can this be justified? This problem spills over to the next stage where if the prisoner is not fit for execution, the doctor has to treat him to restore his fitness. Issues arising here are that of medical duty to treat illness against the concomitant result that good health will hasten the death of the patient at the hands of the executioner. In the case where the doctor prescribes the drugs to be used in the execution, the problem is that it appears he is not behaving as doctors should. Some even say that it is a perversion of the medical practice. If it is, it needs a justification. I will deal with these issues and then see how they can be justified.

The general objection to medical evaluation of a prisoner's fitness to be executed is that medicine's goals are health and life saving, and anything that seems to be against these is impermissible. Since evaluations seem to be against these, they are impermissible.[78] Bonnie has advanced a different angle to the objection and I therefore elect to follow him more closely than the other objections that are general. Some object to medical evaluation of whether a prisoner is fit for execution on the grounds that "execution competency evaluations cross a boundary between participation in the administration of *justice*, which is ethically permissible, and participation in the

[76] a point made by Bonnie (1990:13).

[77] Beauchamp & Childress (1989:120ff) say that there are three obligations arising from the principle. It means doctors ought: not to inflict harm or evil, to prevent evil or harm and to remove evil or harm. The idea that doctors should promote or do good is not as clearly a duty as the other three. It would be recommended though.

[78] It might be that when a doctor makes a medical evaluation of the prisoner's fitness to be executed he is not related to the prisoner as a patient; in which case, it could make a moral difference.

administration of *punishment*, which is ethically objectionable" (Bonnie, 1990:14). This will dent the image of the doctor as healer in the popular mind. This argument seems to beg the question of whether there can be just punishment. Bonnie agrees that such an argument is unconvincing. This is because there is an analogy between medical involvement at the pre-sentencing stage and at competency evaluation. There seems to be an acceptance that medical participation by providing forensic evidence in a capital crime investigation is not morally problematic whilst execution competency evaluation is.[79] But,

> An execution competency evaluation is not obviously distinguishable from other modes of clinical participation in the correctional process, including for example, the classification of prisoners for institutional assignment, the evaluation of a prisoner's suitability for placement in a mental facility, or the evaluation of a prisoner's fitness for parole. Like execution competency assessments, these are evaluative tasks, sought for the purpose of helping the relevant decision makers decide *how* to administer the punishment prescribed by the court. They therefore seem more analogous to evaluations conducted during the trial process than to administration of a lethal injection.
>
> A clinician's role as an evaluator ... is independent of, and not inherently incompatible with, his or her healing or therapeutic role as long as the roles are kept distinct. There is no qualitative difference, ... between sentencing evaluations sought in capital and noncapital cases, or between capital sentencing evaluations and execution competency evaluations. ...Execution competency evaluations do not, then, run afoul of the postulated distinction between participation in the administration of justice and participation in the administration of punishment (Bonnie, 1990:14).

The supposed distinction between medical participation in the administration of "*justice*, which is ethically permissible and participation in the administration of *punishment*, which is ethically objectionable" needs closer examination. I contend that this distinction helps the argument for medical non-involvement only by assuming that medical involvement in **punishment** cannot contribute to the administration of justice. It seems to be the case that if medical involvement in the administration of justice is morally acceptable, justice might involve the practice of punishment.

When a medical doctor gives evidence that might incriminate the defendant in a capital trial, and the defendant is found guilty and sentenced to death, even in cases where such evidence was critical for judgement, the evidence given by the doctor and the execution are distant from each other. There are many intervening factors such as appeals, retrials and clemency. This would suggest that the medical evidence though important, is never decisive. But in the case of execution fitness evaluation it is morally certain that the medical doctor's opinion that the prisoner is fit for execution will lead to his execution within weeks, days or even hours. The difference in proximity to the prisoner's death between involvement at investigation together with giving evidence during trial and execution fitness evaluation is accidental and not essential to the effect of the doctor's contribution to the execution. A suggestion to the contrary would seem to imply that a contribution to the death of a prisoner closer to the execution rather than further is worse than a contribution to his death further down the line irrespective of the extent, quality or significance of that contribution.

But what seems to be at issue here is the level and significance of the contribution.

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[79] BMA

For example, does a person who prepares a condemned prisoner's final meal contribute to the process that results in his death more than someone else who routinely prepares meals for death row inmates not due to be executed immediately? Let us suppose for argument's sake that there is something morally wrong with preparing meals for death row inmates. The one who prepares the final meal does not seem to be morally worse than the routine cook in terms of their contribution to the particular execution simply because his contribution is closer to the execution.

I also agree with Bonnie (1990:14) who points out that:

> the case against participating in a capital sentencing evaluation actually would seem to be stronger than the case against participating in a routine execution competency evaluation. In the context of a sentencing proceeding, the expert does not have effective decision-making authority; but the expert's opinion may very well increase the likelihood that the defendant will be sentenced to death. In the context of a competency evaluation of a prisoner whose appeals have already been exhausted and whose execution date has been set, the prospect that the prisoner will die is now nearly certain, and the expert can alter the prisoner's situation *only* by extending his life. By saying "yes, he is competent," the expert does not have any greater contributory role in effecting the prisoner's death than does an attorney who decides that she does not have sufficient doubt about her client's competency to raise the issue at all.

As Bonnie has pointed out, when a medical expert determines a death row prisoner's competency to be executed, he may extend the prisoner's life if he says that the prisoner is not competent. He may also contribute to its shortening when he says the prisoner is competent to be executed. Should the medical expert help in the shortening of the prisoner's life by saying the prisoner is fit for execution? It would appear that since the prisoner has been sentenced to be executed when fit, the morality of his death depends on the moral authority of the death sentence imposed on him.

MEDICAL RE-EVALUATION OF COMPETENCE TO BE EXECUTED

A prisoner who has been judged to be incompetent for execution can be presented to the doctor for reassessment so that he decides whether or not the prisoner's incompetence has been removed. If execution competence evaluation is acceptable as morally right it appears even at this point reassessment would be acceptable for the same reasons as initial execution competence evaluation is. Medical evaluation of a prisoner's competency to be executed is significantly similar to medical re-evaluation of the prisoner if he has been judged to be incompetent. So there is no need to make a moral distinction between them.

MEDICAL TREATMENT TO RESTORE COMPETENCY TO BE EXECUTED

Now let us turn to the next question. If the doctor has determined that the prisoner is incompetent to be executed should he treat him to restore competence? There are three possible responses to this question. One is that doctors should always treat. The other is that they may sometimes treat, and the third is that they should never treat. The National Medical Association has rejected the "never treat" position in favour of the view that the

physician's primary ethical responsibility is to provide treatment, regardless of the prisoner's legal status (Bonnie, 1990:16). The American College of Physicians et. al. (1994:36), however, say that arguments against treatment to restore competency to be executed are ethical ones, and they go on to condemn psychiatric treatment that has the effect of restoring competency to be executed as unethical. They also argue that:

> one can imagine circumstances in which an ethic of commitment to patients as whole persons might lead a psychiatrist to consider the legal consequences of therapeutic success and nonetheless decide to treat. For example, a delusional prisoner's self-mutilating behavior or a severely disorganized psychotic inmate's inability to eat invites the judgement that the urgency of relieving agony or forestalling an immediate threat to life outweighs the prospect of execution. This possibility merits an exception to the proscription against treatment that might restore the condemned to competence. But this exception should be sharply limited, to cases of **extreme suffering** or **immediate danger** to life.[80]

The idea of "immediate danger to life" in the context of death row is interesting. It appears as if there is a moral difference between dying from disease and dying from execution. At least that is what may be inferred from the above position. It is however not very clear that it is morally better for a prisoner to die from disease than from execution. It might be cruel and unreasonable to revive and treat a prisoner who collapses on learning that his final appeal has been unsuccessful and that he is to die the following day. If the prisoner would die without medical intervention the policy of non-intervention might be a more humane one than the act of reviving him only for the prisoner to face another agonising twenty-four hours of anxiety before his execution.

The problem is that the doctor who treats to alleviate suffering knows that the success of his action will lead to an immediate execution of the patient/prisoner. Should he treat in spite of the consequences? As indicated above the medical associations seem to think so. They also say that:

> treatment that restores death row inmates to competence for execution is widely believed to be unethical. However, some prison psychiatrists contend that it is ethical so long as it is done for the **purpose** of relieving the psychiatric symptoms, rather than for the purpose of killing the inmate. To proponents of this view, the legal consequences of treatment success are ethically irrelevant. Adherents of this view see themselves as acting within the Hippocratic tradition even when successful treatment leads to the killing of the condemned. In so doing, they distort the Hippocratic commitment into an ethic of indifference to patients as persons. This indifference is underlined by the obviousness of the **penal** function that such treatment serves. However the treating psychiatrist understands his or her role, the ultimate, **public** end furthered by clinical "success" is the execution of the condemned. Psychiatric treatment that has the **effect** of restoring competence for execution should thus, as a rule, be regarded as unethical (The American College of Physicians et. al. (1994:43.

Presumably the same would apply if the prisoner suffered from a physical condition. The physician would, according to the above position, not be allowed to treat on the same grounds.

If it is normally considered to be unethical for a doctor to treat a prisoner when the success of such a treatment restores competency to be executed, the issue which arises is whether or not it is more harmful to treat the prisoner to reduce suffering or not to

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[80] The American College of Physicians et. al. (1994:43). In a footnote they state "Anti-psychotic treatment on death row to relieve suffering is consistent with the emerging consensus that preservation of life should not always take priority over the relief of suffering. See, for example, Council on Ethical and Judicial Affairs. Withholding life-prolonging medical treatment. *Journal of the American Medical Association* 256:1986."

treat him in order to stave off his execution. Pain and suffering alleviation is as genuine a medical aim as saving life. One might think that the latter should take precedence over the former in case of a conflict. But that is not the case. Take a prisoner who wants to be treated in spite of the danger of being rendered competent to be executed. He does not impose a duty on the doctor to try saving his life by refusing to render him competent to be executed through treating him. This is the case even if the prisoner is in pain because, as a patient, he might have the moral right to refuse treatment. On the other hand, a prisoner who does not want to die might impose a prima facie duty on the doctor to save his life by not treating him. So the doctor might have a moral problem when the treatment he gives might lead to his patient's death. Here the real question is whether the person is prisoner first and patient second, or the other way round. I would justify his treating the prisoner on the grounds that a morally acceptable sentence (if capital punishment is moral) should be carried out with the help of a medical doctor as demanded by justice. This would suggest that the subject is prisoner first and patient second. If that is the case, the subject's rights as a patient are overridden by the physician's duties as an agent of the state, since the state has the moral duty to impose the punishment on the subject as a prisoner.

Bonnie (1990:16) argues that:

> Given the prisoner's unequivocal preference for life, I see no way to justify treating the patient on the grounds that he will benefit. If the prisoner is treated, it will be for the sole purpose of serving the state's interests in carrying out his execution. Is it ethically permissible for members of the "healing professions" to devote their professional skills to such a mission?
>
> I do not see how it can be. Because the clinician's actions no longer have any link to the prisoner's own interests—he would be an object of treatment, not a patient—the clinician would be serving a role that is ethically indistinguishable from the physician who administers the lethal injection of barbiturates.

If Bonnie is right, and if it is the case that the doctor is allowed to treat a prisoner against his will in order for the state to carry out a morally acceptable sentence, and that is comparable to the physician who administers a lethal dose, what is the implication? It would appear that doctors might execute by lethal injection without moral problems. But if medical involvement in the actual execution is not justifiable on these grounds, is there any comparable activity that doctors carry out? "... the preservation of life is not always the paramount ethical value, even in the context of physician-patient relationship. As a matter of principle, it would seem difficult to sustain the argument that forensic testimony that might lead to execution violates nonmaleficence even though the presentation of testimony that might lead to profoundly debilitating imprisonment does not" (Bonnie, 1990:13). But we know that medical participation in the investigation of capital crime by providing forensic evidence and during such trials by providing incriminating evidence together with evidence at the sentencing stage are allowed. If convictions do not lead to the prisoner's death but to a prison sentence which immediately results in his immense suffering comparable to death, it would appear to be unethical for doctors to be involved in such activities for the same reasons that they should not be involved in killing or contributing to it.

MEDICAL INVOLVEMENT IN WAR AND CAPITAL PUNISHMENT

Is the medicalisation of capital punishment comparable to the military doctor role? One answer is that capital punishment medicalisation involves the killing of a human being whereas the military doctor role involves healing and not killing. One may respond to such a position by saying that both capital punishment and the military have to do with self-defence and the furtherance of human well being in the final analysis. Punishment in general has to do with the protection of society's members. Capital punishment is at least supposed to be for the protection of society against murderers, or for the promotion of a just system of punishment. The military on the other hand is an institution by means of which society can defend itself against external enemies. So both capital punishment and the military (sometimes by waging a war) serve a similar purpose at different levels. What is of particular moral importance is that the two purport to or do protect society by killing human beings.

There is an argument that doctors in the army do not get involved in combat so that makes them different from doctors who do the actual killing of prisoners. In the previous chapter we have seen that medical doctors in the army say that in accordance with the Geneva Convention they may not be engaged in combat situations as doctors. This is Amnesty International's view as well. Assuming that there is a just war, and that soldiers can legitimately (in the moral sense) kill their enemy in battle, it does not seem to be morally justifiable to say that doctors should not kill their enemy in battle as well unless we can point to a morally important difference between an army doctor and other soldiers. If we cannot show that enemy soldiers' deaths at the hands of an army doctor is morally worse than their deaths at the hands of the other soldiers, I believe there is no reason why army doctors' roles in battle should not include planning battles, attacking enemy positions and being actively involved in combat.[81] Now if military doctors can attack enemy soldiers, it seems the medicalisation of capital punishment and the killing of enemy soldiers in battle by military doctors may be comparable.

Regarding capital punishment medicalisation, if capital punishment were morally acceptable, we would have to show a morally significant difference between the death of a prisoner at the hands of a non-medical executioner and his death at the hands of a medical doctor who becomes an executioner. The argument for the non-involvement of doctors in capital punishment so far is the appeal to the special nature of role morality that sets medical ethics apart from ordinary morality, a thesis we have already rejected in chapter two. Now let us see whether there is any comparability between the military doctor role and the executioner-doctor role.

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[81] One objection could be that it might be wrong for a doctor to kill soldiers in war whereas it makes no difference for soldiers to kill the doctor. This question has to be understood against the background of the international convention, which demands that medical centres and personnel should not be attacked during wars and that the medical personnel should not be engaged in combat. The problem however is that if a doctor can defend his patient against attack even to the point of killing the attacker, it implies that he could actually kill enemy soldiers. This is because if we accept that the doctor's friendly soldiers are his patients we would have to understand that his duty to them might include protecting the soldiers against attack, and in battle, he can do so by killing the enemy soldiers. If that is true, it means the military doctor is effectively involved in combat. If the doctor can be involved in this way, it seems to give the enemy soldiers the right to kill the doctor as well if they can, on the basis of self-defence.

MILITARY DOCTOR ROLE COMPARED TO THE DOCTOR-EXECUTIONER ROLE

As for whether medical doctors should take up the job of executioner we can take the cue from military doctors. As shown in the last chapter, medical doctors may choose to be career soldiers and leave the medical regiments of the army. Inevitably, if they get involved in war they may have to kill either to survive personally or to do so following legitimate orders of their army commanders. They may also be in command positions and therefore have to order others to shoot and kill enemy forces and at times innocent civilians. Leaving a medical regiment to become fully involved in combat may be seen as an attempt to resolve an apparent conflict between being a soldier and being a medical doctor. This strategy may be employed as well in the case of a medical doctor involved in the prosecution deciding to become an executioner. If a doctor quit practising medicine to become an executioner it may raise moral problems. The problem is whether it is morally wrong for a doctor to kill either in battle or in the execution chamber. I think it is morally right for a doctor to kill in those circumstances as long as the war and the execution are morally justifiable.

The problem with resigning from active medical practice to be fully engaged in either military or execution duties is that it does not solve the fundamental issue of what makes one a doctor. Is it practising medicine, or is it the knowledge of medicine?[82] When a doctor stops practising medicine he can still retain, advance and reshape his medical knowledge. I therefore view the fact that a military doctor stops practising medicine in order to be fully involved in the combative aspect of the army as an unsuccessful attempt to solve the apparent conflict between the roles of doctor and soldier. I think it is the same with the case of a doctor quitting medicine to become an executioner. This problem is raised by the fact that the likes of medical associations and Amnesty International refuse to accept that doctors should kill people in morally acceptable contexts just like other people do. The separatist thesis might have contributed to this as well. That aside, it seems to be reasonable to accept that the medical doctor can quit his practice to become an executioner just as a military doctor leaves his practice to become a career soldier. The arguments are similar. If the military is morally acceptable as a means of self-defence and by extension, war, and a military doctor role is accepted as a contribution to that effort, one may similarly argue that if capital punishment is a morally acceptable way of defending society the doctor can make a contribution to that in a similar way to his contribution to the army. The doctor can quit medical practice to be fully occupied with executions as a medical executioner.

When a military doctor quits his medical regiment to become a career soldier and thereby get involved in combat roles, there is a chance that he might use his medical knowledge in the battlefront. He can use medical techniques to treat friendly soldiers who can go back and fight whilst he himself is fighting. He is not prohibited from making use of his medical experience in dealing with the soldiers as demanded by his non-medical role. This is because, as someone with medical knowledge, he is allowed to

[82] This might be controversial. But it seems to be the case that without the knowledge of medicine there is no way one can practice as a doctor, whereas one can have the knowledge of medicine and still chose not to practice as a doctor. The important thing for our debate here is that when one has medical knowledge he can use it for non-medical purposes even if he is not practising medicine.

treat patients in an emergency even when he is not practising. If that is acceptable, it seems to be unnecessary for the doctor not to treat soldiers who get injured in combat because a war is an emergency situation. This would suggest that maybe even in the case of a medical doctor who quit medical practice to become an executioner might make use of his medical knowledge to enhance the quality of his new position.

The difference between a military doctor who quits practising medicine to be involved in combat and a doctor who becomes an executioner is that the latter uses medical knowledge to execute the prisoner. This is what the medical associations object to. They do not want doctors to train executioners. Whilst this prohibition is based on the traditions of medical practice, its moral basis is of doubtful validity. If capital punishment is morally acceptable, what moral basis is there for prohibiting the involvement of the medical profession? There seems to be something wrong with the argument that doctors should not be involved in something that is morally right when done by other people.

There is a parallel between medical involvement in capital punishment in the way suggested above and the military doctor role in the army. Both involve an apparent conflict between the role (execution/shooting enemy soldiers) and the doctrine of beneficence/non-maleficence. The victims of their operations are either injured (in war) or killed (in both capital punishment and war). So if there is a moral problem, it is not with the doctor's contribution to these practices but with war and capital punishment. But if these practices can be morally justifiable, it appears that the involvement of the medical profession can be justifiable as well.

MEDICAL INVOLVEMENT IN PREPARING A PRISONER FOR HANGING VERSUS GIVING MEDICAL EVIDENCE IN A CAPITAL TRIAL

Now let us look at the medical involvement in capital punishment at other stages. Doctors can be involved in giving evidence against a capital crime defendant during the trial and at the sentencing stage, and these are acceptable to the medical associations and Amnesty International. In the case of execution by hanging medical participation beyond these stages includes weighing the prisoner before execution and making calculations of rope length, strength etc. in relation to drop and the prisoner's weight (The American College of Physicians et. al., 1994:32). For example in

> Washington, Westley Allan Dodd was executed by hanging in January 1993. Dr. Donald Reay, King County Medical Examiner, reviewed the Washington State Penitentiary's preparations for the hanging and offered opinions on "the efficiency of the hanging procedures" including cause and timing of death and the likelihood of pain. Dr. Reay has indicated that he is personally opposed to the death penalty and that the opinions he expressed "are based on present day medical evidence (The American College of Physicians et. al., 1994:11).

These activities are not acceptable to the medical associations and Amnesty International as they are held to be against medical ethics. The question is whether preparations for hanging are comparable to any routine medical activities. In the case of Dr Reay for example his participation amounts to providing information to those who are going to execute the prisoner. He may be understood to be saying, "I do not agree with what you intend to do, but if you are going to do it anyway, this is the way to do it

efficiently and with less trauma to the prisoner." In the case of a medical doctor giving evidence against a capital trial defendant, the following seems to be the case. The accusers tell the doctor that they want to prove that the accused committed a crime, and if successful, they will have him executed. However, they need scientifically respectable, authoritative and acceptable information that only he as a medical doctor can provide. As Thorburn (1987:639) says, "medical testimony that supports aggravating circumstances puts a forensic expert in the position of advocating a death sentence." The medical associations seem to be saying that the doctor can give the information that will make hanging the prisoner probable without any moral problem in the case of giving evidence, but would violate medical ethics if he told them how to hang the prisoner. This raises the question as to whether later stages of the capital punishment process are comparable to earlier ones, and justifiable, when the early stages are.

The difference between the two kinds of participation is that sometimes one is vitally important for execution to occur eventually, but the other does not determine the execution's occurrence. A murder case may sometimes never be solved unless medical knowledge is employed. This can happen in the case of forensic medicine. DNA and sampling can be used to identify a suspect, for example. This means that whether a suspect is identified, brought to trial, found guilty and subsequently executed depends on a medical doctor. It would suggest a medical doctor in that case is responsible at least to the extent of his contribution to the conviction, for the execution of the prisoner. If we compare this with preparations for hanging we find that when a prisoner has been found guilty without the agreement and approval of the medical doctor, and he is about to be hanged, the doctor cannot be held responsible for the hanging. The prisoner would be hanged independently of the doctor. Now when the doctor comes in at some point before the hanging and advises that the most effective and less painful hanging method is A, he is not taking responsibility for the death of the prisoner. If anything, the doctor is taking responsibility for the amount of pain that the prisoner would suffer and the amount of unpleasantness that the executioner would experience.

"PARTICIPATION" AND "PROFESSIONAL INVOLVEMENT"

Medical associations are against medical participation in capital punishment including "attending or observing an execution as a physician" (Thorburn, 1987:15). Notwithstanding the above prohibition, medical associations say that doctors may be involved in a way that does not constitute "participation". The activities not constituting participation and therefore permitted for the doctor include "witnessing an execution in a totally non-professional capacity, witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a non-physician capacity and takes no action that would constitute physician participation in an execution" (Thorburn, 1987:16). A medical doctor would not be allowed to attend a hanging unless the person to be hanged requested it. This would suggest that the medical associations see a morally significant difference between witnessing a hanging as a professional medical doctor and doing so at the request of the person to be hanged. The suggestion also would be that the two are not comparable

morally. The argument that there is a difference between participation as a professional and participation as a non-professional is sustained by the thinking that if people can take different roles they should be seen in those roles independently of anything else. This might be inspired by the separatist thesis of morality that we dealt with in chapter two. It is however important to note that when a doctor attends a hanging, it is that person doing so, not different capacities. When a doctor, for example, had his friend on death row and was invited to attend his hanging, it would not just be a doctor attending or a friend. It would be the person who happens to be a friend and a doctor.

There is a problem with what "professional" means. If a particular doctor went to observe a hanging on behalf of the World Medical Association he would presumably do so in a professional capacity. He would sit and observe the hanging just like other witnesses attending in their different capacities. Supposing he does not do anything but sit and watch, that would not be different from what he would do if he went there to do the same because the prisoner requested him.

The important question that one may ask is why the medical profession approves a doctor's presence at a hanging when the prisoner has requested it, and whether the government may not make such a request for the same reason. If the main reason for medical approval of the prisoner's request is that the prisoner is against the might of the state, in other words, the medical profession playing the role of advocacy, it would be a non-medical role, which can be played by the legal profession. But if the reason for medical approval of a doctor's attendance at a hanging when the prisoner requests it is for the prisoner's sake, how is that different from when the government requests it and the prisoner does not object to such attendance? If the presence of a medical doctor at an execution has any beneficial consequences for the prisoner, does that just depend on the prisoner requesting it? It would appear that if the doctor is needed for the emotional and psychological well being of the prisoner, that might still be the case even when he does not request for the doctor's presence. So one would think that the better policy would be to let doctors attend unless the prisoner objects just like in other medical services.[83] It is true however, that a prisoner is different from a patient and so their relationship might not be the same. But that does not mean a doctor can relate to a person in role that is different from the patient-physician one.

Should the wishes of a condemned prisoner be granted simply because the medical professionals have to help the prisoner who is against the mighty state? And, is it morally right to grant the wishes of a condemned prisoner? If a medical doctor does a moral wrong when he attends an execution in his professional capacity, but does not when he attends an execution at the request of a condemned prisoner, shouldn't the same policy apply regarding the execution itself? It is morally wrong for a medical doctor to professionally execute a condemned prisoner, but it is not wrong if the condemned prisoner specifically requested him to do so? One can easily imagine a situation where a prisoner argues that he is willing to die at the hands of his physician than anybody else, and actually it would be a great honour if the physician would

[83] The doctor's presence might be mistaken to mean his approval of the execution itself so that it might actually make a difference that he attends in his official medical capacity. But that should not be a problem as such unless there is something wrong with the execution itself or medical involvement. If there is nothing wrong with the execution then we cannot assume that there should be something wrong with medical involvement.

accede to his request. If the prisoner should be executed and there was nothing morally wrong with the execution itself, there does not appear to be any reason why the doctor would not execute the prisoner, and according to this argument, even do it professionally.

LETHAL INJECTION

Lethal injection is more interesting than the other methods of execution because "it is the first time that lifesaving medical technology will be used to execute people" (Malone, 1979:5). For example, Dr Richard Hodes, an "anesthesiologist who in the operating room daily uses the same drugs proposed for lethal injection (drugs that the Oklahoma law specifies 'continuous, intravenous administration of a lethal quantity of an ultrashort—acting barbiturate in combination with a chemical paralytic agent') felt uncomfortable with lethal injection and helped the defeat of a state proposal in 1979 to introduce the type of execution. He claims that his main objection is the fact that a technique used for healing purposes is also being suggested for use to take life. This argument assumes that there is a moral difficulty with using the same thing both for saving life and for taking it. The use of medical techniques that are for saving life in taking it is not necessarily a problem. This is analogous to analgesics that are used in overdoses for euthanasia purposes, but also for relieving merely temporary pain in cases that do not threaten life. In the case of analgesics being administered for euthanasia, one would not validly object that analgesics should not be used for euthanasia because they are used for pain relief in these other cases of non-life threatening pain. The argument would rather be that euthanasia is wrong, if it is so.

Why, then, is it objectionable for doctors to lethally inject condemned prisoners? Some of the answers are that doing so is in violation of the Hippocratic oath,[84] it either degrades the medical profession or upgrades executions, or does both,[85] and it may confuse the ordinary people as to what the medical professions stand for.

Maybe there is a morally significant difference between a doctor killing in self-defence and executing by lethal injection. In the case of self-defence the doctor is in immediate mortal danger and therefore the killing of the attacker is inevitable but necessary if the doctor is to survive, but in the case of lethal injection the prisoner poses

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[84] Medical associations and Amnesty International hold this. See for example American College of Physicians et. al. (1994). and Patrick Malone (1979:5), who says "There seems little argument that a physician who participated actively in an execution—by inserting the needle or pushing the plunger—would be violating the Hippocratic Oath."

[85] Malone, quoted above, says that one of the objections is that "Hodes and other physicians opposed to lethal injection argue that its real appeal is not so much that the prisoner presumably feels less pain, but that a medical veneer has been added to the act. One of the few physicians who has written on lethal injection, Dr. Lonnie R. Bristow of San Pablo, California, says: "Lethal injection is creating a false image about an act which is quite final and quite dehumanizing. Traditionally the giving of injections has been done by physicians, nurses and other health professionals. Generally those groups are considered to have the highest developed quality of love for humanity. So that upgrades this act into something humane and acceptable" (*Forum on Medicine*, June 1979).

Or, if it does not upgrade capital punishment, Dr. Hodes worries that it downgrades his professional tools. He notes that from a practical standpoint, exactly the same dose could be administered to the prisoner as to a surgical patient, although prison officials are likely to use larger doses to make certain."

no immediate danger to anyone. This difference is not of moral significance unless there is a supposition that the prisoner should not be killed. If he is seen as someone who meets the "requirements to be killed" he is in the same moral category as the attacker who has to be killed. Further, the doctor does not have to be in danger himself in order to kill. Military doctors kill in defence of their patients, and they do so even when they are not personally in immediate danger. We note here that the doctor is allowed to kill the person threatening his patient, and that makes this person one who "qualifies to be killed." His moral status at this point is equal to the foetus that is the object of an abortion, the patient to be killed in euthanasia and the condemned prisoner.

The objection that medical doctors' participation in executions is a violation of the Hippocratic Oath though it has its supporters, is not without difficulty. The oath is believed to bar doctors from participating in lethal execution and demands that they agree and swear "to give no deadly medicine to anyone if asked, nor suggest any such counsel" (Singer, 1993:175). This obviously would seem to exclude unequivocally medical execution participation whether by lethal injection or poisoning. This proscription is based on the supposition that doctors should not kill human beings. But we find that if euthanasia is justified, then doctors can do precisely that—give deadly poison. On the other hand if the prohibition of giving poisons is based on the prohibition against killing human beings, we know that there are cases where the doctor actually gets involved in such killing. The examples are abortion (if the foetus is considered a human being), war and self-defence. So the violation claim has to be made with qualification. It is also noteworthy that the same oath prohibited doctors practising surgery (Amundsen, 1978:27).

The argument that lethal injection degrades the medical profession and upgrades capital punishment is based on a theory, which holds that some professions are morally better than others are.[86] But this is problematic since if professions are morally acceptable or morally right, it does not seem to be clear just how one can be morally better than another. If the executioner role were to be taken as a morally right profession it does not seem to be clear how it would be morally worse or less moral than the medical profession. Unless one holds that there is something morally wrong with capital punishment it does not seem to be obvious that one who carries it out legally and morally is a lower mortal than a medical doctor is.

If there is nothing morally wrong with capital punishment, and there is a danger that medical involvement in it might confuse ordinary people to such an extent that they could mistrust doctors, the best would not be a rejection of the medicalisation of capital punishment. It appears the best would be to teach people to understand and accept that some people have to be killed at times and doctors may be better placed to do it. The argument to protect the ordinary people in this way seems to be unnecessarily paternalistic supposing that the ordinary people lack understanding. This is not very obvious since democracy seems to suppose the intelligence of the ordinary masses.

Miller and Brody (1995:15), who support physician-assisted suicide, do not base their objection to the medicalisation of capital punishment on the morality or immorality of capital punishment. They argue rather "whether or not it can be morally

[86] I acknowledge that some thinkers believe medicine for example, is a morally better profession than business. I do not accept this position. I believe that any morally right profession or human activity is equal in quality to any other morally right activity.

justified, physicians should not be involved as executioners." They have the following reasons: a) The physician acts as an agent of the state and the patient-centred medical activity is lacking in lethal injection. b) Lethal injection by doctors violates professional integrity because: i) No medical goals are served by physician executions—lethal injection is not a medical procedure or treatment. ii) It does not respond to a medical condition effectively. iii) There may be no physician-patient relationship. iv) Lethal injection is not intended for the benefit of the prisoner. v) The prisoner would never have chosen lethal injection if it were not for capital punishment. vi) The physician does not serve the interest of the prisoner but that of the state.

There seems to be a problem with Miller and Brody's objection that the physician acts as an agent of, and serves the state when he executes the prisoner by lethal injection.[87] This seems to suppose that there is a moral problem with serving the state. Supposing capital punishment is morally right why would helping the state to execute it be morally wrong? We have seen that physicians can serve the state in the army as military doctors without apparently any moral problem. We also know that physicians can serve the state in investigating crime, and the professional testimony provided during capital trials classified as involvement that is allowed by medical professionals as distinguished from medicalisation dealt with in Chapter One above. This would suggest that helping the state in itself is not morally wrong. This is the case even when such help is against the prisoner as when a physician testifies at the sentencing stage of the trial. The patient-centred medical activity does lack in these cases, which are taken to be morally acceptable.

As I have already pointed out, Gewirth has proposed that there are justified institutions that are formed by society to protect moral rights. The state is one of them. I have also suggested that it is on the basis of this view that medical ethics might be overridden by the demands of morally justified institutions if that helps them to better protect moral rights. This is also in accordance with the Millean theory of utility, where the doctor would actually have a moral duty to serve the state. So service to the state by itself is not a morally objectionable thing for a doctor to do.

If we apply Miller and Brody's argument as advanced in favour of euthanasia it seems to be the case that unless a physician has a conscientious objection to lethal injection, they can carry out the practice without violating their professional integrity. According to Miller and Brody one of the goals of medicine is to help patients die peacefully and with as little pain as possible. In the case of capital punishment (lethal injection) we have a patient faced with certain death albeit caused by humans. If there is no moral objection to the 'causing of the death', and if the physician cannot do anything to stop the death occurring, it appears the duty of benevolence would demand that the physician step in to minimise pain (counselling and sedation).

When the state has condemned the prisoner to the gallows, who else should be there but the physician so that he does not **abandon** the prisoner to the pain and loneliness that is visited upon him by the threat of imminent death. A physician would feel that there is something wrong with him if he can abandon the prisoner to be alone without medical attention at his hour of need, on his deathbed of execution.

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[87] Acting as an agent of the state without any patient-centred activity is a reason for objecting to lethal injection as far as Miller and Brody are concerned. The doctor's patient-centred activity is the morally justifying reason for medical involvement, if I understand them well.

The denial of the death row prisoner's status as a patient seems to be convenient to those against the medicalisation of capital punishment. When I visit a doctor in his role as a physician there is no doubt in my mind that I *am* his patient even if it turns out that I am not ill. There does not seem to be a doubt in my mind that a death row prisoner about to be executed is likewise a patient. Only his condition is man-made and other conditions may not be. The death row prisoner about to be executed whose life cannot be saved by the physician unless the state commutes the sentence or indefinitely stays the execution can rightly be seen as a patient. This would therefore answer the objection that lethal injection does not serve any medical goal—the goal to help patients die with dignity, reduce pain and physician dedication to the prisoner-patient—not abandoning him to a cruel and painful death, or at least more painful than lethal injection.

The history of medical involvement in capital punishment clearly shows that doctors have always generally sought to reduce death row prisoners' pain if executions are to continue. So one would not necessarily accept that lethal injection is not for the benefit of the prisoner-patient. Lethal injection ***is*** for the benefit of the prisoner-patient. It is also consistent with the state's intention to execute him.

CHAPTER 6

KANTIAN THEORY

INTRODUCTION

We have made a distinction between medical involvement in and the medicalisation of capital punishment. Medical involvement in capital punishment is the participation of doctors in the process of capital punishment prior to and after the execution itself. The medical associations approve of such participation, save that they disapprove of involvement in prisoner organ donation—especially when the prisoners do not consent. They are against medicalisation—involvement of doctors in the actual execution by medical techniques, together with the necessary preparations for the execution. Here I want to deal with the process itself from a capital trial to the execution and beyond, asking how a Kantian argument can or cannot be used to justify medical involvement in the process at different stages.

My argument is that whether or not Kant's claims about capital punishment are acceptable, the involvement of doctors in capital punishment is justifiable on Kantian grounds. This arises from the special nature of social institutions that protect moral rights. To do this I am going to give a sketch of Kant's theory of justice and relate it to Gewirth's view of morally justifiable institutions. I will then apply this to the different stages of medical involvement. The stages which I will deal with are: investigation and trial, fitness to plead and stand trial, sentencing stage, treatment on death row, determination of dangerousness to society, fitness/competence determination for execution and treatment to restore competence, tranquillisation, lethal injection and organ donation.

It is right to point out from the beginning that what I present here is "a Kantian perspective" or an interpretation of Kant that accepts that it may be controversial. As Hill points out about the Kantian principle that each person must always be treated as an end in itself and not merely as a means, "despite the warm reception Kant's principle receives from non-consequentialists everywhere, its interpretation remains controversial" (Hill, 1992:201). I hope however that on the whole the interpretation of Kant in relation to medicalisation of capital punishment will not be strange enough to seem entirely non-Kantian. Of particular importance are his ideas of justice (moral and judicial), autonomy, freedom and human dignity and duty for both society and the individual.

CHAPTER 6

KANTIAN THEORY OF JUSTICE

According to Kant the basis of human society is the individuals' conclusion following rational deliberation, that the state of nature cannot continue to be the way human beings should live if they are to realise their nature of being autonomous beings. They therefore enter into a contract and willingly give up their external freedom to a sovereign so as to take the freedom back.[88] In the state of nature, human beings are free to do anything they want. It is not a fact that in the state of nature there is a war of all against all and therefore laws are necessary to coerce individuals to behave justly. It is rather an a priori idea that there is no guarantee that all people are secure from aggression and injury by others, "because each will have his own right to do what *seems just and good to him*, entirely independently of the opinion of others" (Kant, 1965:76). In the state of nature there is no court with the jurisdiction to judge in the case of conflicting claims to individual autonomy and justice. If there be one with such pretensions, it does not have moral and legal force.

Now when people submit to a sovereign, the conditions of the contract are that there should be justice. This justice is nothing but the protection of autonomy. It is "the aggregate of those conditions under which the will of one person can be cojoined with the will of another in accordance with a universal law of freedom" (Kant, 1965:34). And "freedom (independence from the constraint of another's will), insofar as it is compatible with the freedom of everyone else in accordance with a universal law, is the one sole and original right that belongs to every human being by virtue of his humanity" (Kant, 1965:43-44). Within this is contained the freedom of every individual not to be bound by others to do what he or she cannot bind others to do. Internal freedom is an individual's ability to think and will what he or she chooses as a rational being independently of others. External freedom is the ability for an individual to act without impediment from outside her or him. The former type of freedom pertains to ethics whilst the latter pertains to political organisation and hence, judicial justice.

In order to ensure that each and every individual will retain her or his external autonomy, the sovereign, in accordance with the terms of the contract, legislates. Law is an instrument by which the harmonisation or synchronicity of all people's rights may be maintained. This harmonisation or synchronicity of people's rights involves coercion in case of deviance. In the state of nature for example, an individual is not bound to refrain from killing others since he or she cannot bind them to refrain from killing her or him. In civil society however, everyone agrees to be bound by what he or she binds others to do. So the state—executive, legislature and judiciary have the special status of safeguarding every individual's right to autonomy and justice. In civic society autonomy means personal and political liberty.[89] By justice Kant means that not only should people act in accordance with the principle that their actions should coexist with

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[88] Kant (1965:80-81). See also Rosen (1993:128), who says, "without political society, Kant believes, justice is impossible, and so the political state is a necessary condition of justice."

[89] See for example, Rosen (1993:210-211), who says, "the principal value in Kant's political philosophy is freedom. ... turns out to have two dimensions in Kant's theory of justice—one civil, the other political. Civil freedom ... "personal liberty"—is freedom to pursue one's own ends as one sees fit under the protection of the law. Political freedom is the liberty to participate along with others in determining the laws by which one is governed, and by which one's civil freedom is defined. Both types of liberty are morally necessary according to Kant."

the others' freedom, but that when they so act, it is an injustice to hinder them. Coercion is sometimes necessary to curb the hindrance to justice. This can mean that strict justice is the reciprocal use of coercion that is consistent with the freedom of everyone as demanded by universal laws (Kant, 1965:35-37).

The rule of law is important for Kant. The law is inviolable and its institutions are to be respected even if they are imperfect. This is because it is the only way, according to Kant, that justice can be guaranteed. If justice perishes then people would not like to live because as rational autonomous beings, they can only live with their rights guaranteed under the rule of law. When people commit crime, they as it were, cast themselves out of the society. They destabilise or threaten the existence of the law. Punishment may be seen as a ritual or symbolic re-admission of one back into society—a payment whereby one's account and the stability of the law, are restored to balance. When a person is not punished for a crime, it is like they are where they should not be, and that is an injustice. Injustice threatens the existence of society since it probably leads to the break down of the rule of law, without which there is no instrument to regulate in a just manner, the interactions of human beings in their pursuit of happiness and autonomy.

All these mean that the suzerain or government as the final appeal for just adjudication is supreme and therefore whatever they decide should prevail over the general population. This also means the laws, institutions, roles and demands from the government are primary and therefore are morally binding more than what some people in the state might conceive to be acceptable. From this we can understand that the law for example, and specifically the criminal law that sanctions capital punishment is more primary than medical ethics. So when the legal system devises means to pursue its goal of protecting rights, it has the authority to demand the participation of those who are able to serve in that respect. In the case of capital punishment doctors and people with medical knowledge seem to be able to provide some aspects of that service more than others are. They therefore have the duty to help the state because otherwise it would not be able to do its work. They have the duty to help the state even if that help may be against medical ethics.

The moral basis of the state's existence does not guarantee the promulgation of morally acceptable or just laws. This means in trying to carry out its just mandate, the state might employ unjust means, and capital punishment could be an example. If that is true, it could mean that the demand for doctors to be involved in capital punishment would involve them in the commission of injustice. So to show that the state and its institutions are morally justified is not sufficient to show that capital punishment is just. It is not sufficient either in showing that medical doctors should be involved in capital punishment.

My argument is that Kant has advanced a justification of capital punishment, which may or may not be acceptable. Moreover capital punishment might be justifiable on non-Kantian grounds. But if the state, its institutions and capital punishment are justifiable, there is a case for the involvement of doctors in capital punishment. This is because the justification of the state is safeguarding justice. This is done through laws under which doctors operate in their ordinary medical practice. The state guarantees that doctors behave in accordance with medical ethics if that is just. But since justice goes beyond medical ethics, in order to safeguard the former, the state may override the

demands of the latter. This happens in the case of capital punishment—if the demands of medical ethics to save life are just, they might be overridden by the demands of justice where doctors are called upon to participate in capital punishment. This arises from Kant's insistence that stopping somebody from doing what he or she is entitled to do as long as that is consistent with the rights of all those involved is injustice. If the state is entitled to execute criminals, it should not be stopped to do so efficiently by the help of doctors.

If the state and its institutions are justifiable but capital punishment itself is not justifiable, there is still a case for the involvement of doctors in capital punishment. A Kantian justification is the idea of rule of law. It is the idea that laws should be obeyed. Applied to capital punishment it would mean that even if the legalisation of capital punishment is morally unjustifiable, still people should obey it. The fact that it is unjust is enough ground to try and have the law changed, but it is not enough to disobey it. The question is whether people are behaving morally when they obey an unjust law. In as far as they are carrying out their duty to obey the law, they are. This stems from the view that generally people have a duty to obey laws. If people do not obey the law, they challenge the principle of legality. If they do, then lawlessness or state of nature would obtain. On the basis that a state where laws are obeyed is morally better than one where either there are no laws or the laws are not obeyed, the citizen, including the doctors have to obey the law even if it is unjust. If they do, the morally acceptable way to go about it is to try to have the law changed. Otherwise, they would behave illegally, which is morally wrong, and risk the state becoming morally worse when it becomes lawless. We must remember that the purpose of the law is to protect the fundamental right of human autonomy, which would be threatened by the breakdown of the law.

This argument does not account for the fact that it is not always true that disobeying the law can lead to a morally worse society. Under a morally terrible regime for example, it might be morally better to overthrow it and establish a new order. It has to be admitted that such situations are exceptions rather than the rule. The problem with political revolutions however, is that there are no rules governing them. So there is no guarantee that the new order will legislate justly. It is a risky adventure. So if we grant that sometimes it is morally justified to take the risk of disobeying the law, we have to admit that as far as legal justice is concerned, there would be a violation of the law. The violation of the law would be punishable if the law were to be applied consistently and impartially. If the law were applied, nobody would say that the people were treated unlawfully.

The idea here is not to equate legality with morality, but to say that there is a moral reason for obeying the law. The point Kant makes about political revolutions and the law is that there is no law (constitution) that provides for its disobedience. If the law claims to be the ultimate measure to protect rights, it cannot say at the same time that another measure beside itself is applicable. If people are to behave legally they cannot do so by disobeying the law. In the case of political revolutions, they are illegal. For anybody to be morally and legally bound to obey the revolutionaries once they have assumed power there has to be a legal framework in which they operate.

As for medicalisation itself, I suggest that a Kantian argument in favour is possible, namely that there are people who are morally better off dead than being alive, and a death row prisoner is such a person. He has a duty to die—submit to execution—that

arises from his autonomy and human dignity, which would be diminished if he did not take responsibility for his crime. I discuss the Kantian ideal of a rational "honourable" murderer who understands that he needs to be punished by execution for the murder he committed. He cannot flinch from this responsibility and remain rational, as Kant understands rationality and autonomy.

If the death row prisoners have the duty to die, the state, which has the duty to help people realise their dignity and autonomy, should punish them.[90] That is a duty both the murderer and state have. This is how the duties arise. As a rational being, a citizen knows that he cannot commit a crime and at the same time will that his criminality be universalised. So as a rational agent he knows that living in society will include the obedience to laws, which bind everybody without exception, including him—he agrees to be bound by law, including the penal law. The criminal knowingly and willingly breaks the law, knowing the consequences. The criminal ought to take responsibility for his actions. In the case of his criminal behaviour, he has to offer himself for punishment. In the case of capital crimes, he has to give himself up for execution. But then this is what the murderer himself should do. It is an ethical duty that cannot be enforced by laws. The state comes in to punish the offender not because he does not will what is morally good. The state comes in to punish the offender because his or her actions are not consistent with the well being and autonomy of other people. The state here is the referee or guarantor of justice.

The state has the duty to respect a murderer, in other words, treat him as a rational being, by holding him accountable for his rational actions, as this is what everybody has agreed to, and should agree with if they are rational. This is done not only through penal institutions, but also through the legislature, which should ensure that in penal legislation, the punishment is "equal to" or fits the crime. In the case of murder, according to Kant, the most appropriate punishment is the death penalty.

The Kantian argument fits in well with Gewirth's view advanced above. To recall, Gewirth has argued that morality is about the respect of every individual's right to pursue her or his interest and well being without being interfered with as long as the individual does not interfere with others' interest and well being in the process of pursuing here's or his. This right is universal—this is the Principle of Generic Consistency. If he or she does interfere with other's interest and well being, it should result in his or her own rights being infringed. This is done through the establishment of morally necessary institutions such as the state and the legal system. And, just as Kant would say, it is rational that the criminal should expect his rights to be infringed if he violates others' right to the pursuit of their own interest and well being, which he does when he murders somebody.

What is of importance here is why penal institutions are necessary and why they should prevail over medical institutions. Both Kant and Gewirth think that penal institutions are important because they safeguard the maximisation of people's freedom and well being. Gewirth has insisted that justifiable institutions create roles that may or may not be justifiable. When they create roles that are not justifiable it is a moral wrong. This would mean that the morality of capital punishment could be important in

[90] Rosen (1993:174,197) argues that for Kant the state has the duty to: protect individual liberty, enforce contracts and prevent fraud. He argues, "the state has a moral responsibility to ensure the well-being of its citizens."

determining the morality of the medicalisation of capital punishment. I am not aware of Gewirth's view of the morality of capital punishment. His principles however, can be used to justify capital punishment. Gewirth does say that punishment is the justifiable "violation" (infringement) of a person's right because he has violated (unjustifiably) the right(s) of the other(s). Capital punishment can be understood to be the infringement of a prisoner's right to life on account of him having violated his victim's right to life.

If it is the case however, that capital punishment is morally wrong, why should doctors obey the laws that seek to involve them? I insist that there is a justification for the involvement of doctors that can be deduced from Gewirth's theory. The most important thing for Gewirth is the protection of people's pursuit of their own interest and well being without violating other people's pursuit of their own interest and well being. Whatever measure that can promote this will have priority over any other. When the government institutions and particularly the penal systems, have a conflict with the medical institutions, it seems people's interests would be served more when the penal institutions prevail over the medical ones. This is because the medical institutions can better serve the goal of enabling people to pursue their autonomy and well being under the law rather than independently of the law. It is a fact that in many present day societies doctors have to do their work as authorised by law, and the law normally includes things which have nothing to do with medical ethics, and in some cases against or at least inconsistent with medical ethics. An example is the case where doctors routinely tell people about the health conditions of their politician patients, which does not happen in the case of private patients. The reason for this is that the wider society's interests would be enhanced by such behaviour. The case of a highly communicable disease of a private patient where it would have to be announced if necessary is another example.

According to Kant, the commission of a crime is a violation of a contract.[91] In theft there is a threat to the ownership of property by society including that of the offender. Likewise, murder is a threat to life—not only that of members of society but that of the murderer himself. What is at stake when a person commits crime is that he has gone back on his acceptance of the laws of the state, and his actions contradict rationality. The state on the other hand gets challenged to show whether it will stick to its part of the social contract, namely that crime will be punished in proportion to its gravity. If the state and everybody agree that it is not rational to commit murder for example, and the commission of murder should result in the execution of the murderer, the state must execute the murderer. If the state does not execute the murderer, it cannot will that such in action in the face of murder should be universalised—nobody can will that such behaviour should be universalised. If people flinch from their duties and do not honour their contracts, society would disintegrate. If the state did not execute the murderer for example, it would mean that the promise to punish criminality was not truthful. What is of utmost importance however is the viability of the legal system, which could be undermined when laws are not applied and obeyed.

[91] Crime is also an instance of human beings behaving inconsistently with justice, which is the "restriction of one's will to be in harmony with everyone's rational free will in accordance with a universal law." Justice is "a condition in which each individual's external freedom is restricted so as to make it consistent with the freedom of all others in the framework of a common law or system of laws." (Rosen, 1993:9). For one to behave justly, they have to be rational, and this rationality means that one would not commit a crime. The individual is a law-maker, and as such, he cannot commit a crime.

As far as capital punishment for murder is concerned, Kant concedes that the principle of like for like might not fit completely. But an approximation is practically possible. He says that:

> whoever has committed murder, must *die*. There is, in this case, no juridical substitute or surrogate, that can be *given* or taken for the satisfaction of justice. There is no *likeness* or proportion between life, however painful, and death; and therefore there is no equality between the crime of murder and the retaliation of it but what is judicially accomplished by the execution of the criminal. His death however, must be kept free from all maltreatment that would make the humanity suffering in his person loathsome or abominable (Ezorsky, 1972:105).

If the Kantian argument for capital punishment is acceptable, we can look at the position of the doctor in the capital punishment process. A doctor has duties as people, which are categorical imperatives. These are contrasted with duties of virtue like good will or benevolence and love, which are optional. These make one indebted to others. There are on the other hand matters of justice and these are compulsory, as they are categorical imperatives. The doctor as a person has the duty to help at the execution of a convicted murderer. This seems to arise from the fact that the state has the duty to execute the murderer, and, consequently, has the right to demand that some of the citizens carry this out.

Kant has insisted that even if a nation was to dissolve itself those entitled to ensure executions are carried out should execute the last murderer. If only doctors remained in the nation that was to dissolve itself it appears they are the ones to make that resolution to execute the last murderer. So the question then is how this should be done.

One may argue that if capital punishment is indeed a duty as Kant seems to hold, it does not seem to be the case that in present day society doctors are the only people left to execute the prisoners. So if doctors should be involved, there must be special reasons. This matter will be dealt with below. So let us see why doctors should be involved.

INVESTIGATION AND TRIAL

In the process of capital punishment we find that the beginning of possible medical involvement is at trial stage. I argue that doctors should be involved at this stage because they have a duty to contribute to justice. This duty arises from the existence of penal institutions that are justified by their importance for the pursuit of justice. This medical duty is also recognised by the Hippocratic Oath. Justice demands that only deserving people be punished. The investigation and trial are to determine that.

What are the moral issues, if any, involved here? A trial is a process by which determination is made as to whether a suspect has done something wrong. It seems to be a moral issue to make such a determination. That is, there is something morally wrong with blaming someone who has not done wrong. From a Kantian perspective, the determination of moral wrongdoing should be followed by appropriate punishment. So it matters that there should be proper investigation following the commission of a crime. As all members of society[92] have the duty to do their part. In particular doctors must help, not because they feel like it, but as a matter of duty attached to their role. That is

[92] If we construe the Kantian position to imply this.

why the forensic specialist gives his input when the police take material from the crime scene for his analysis. The forensic doctor cannot say that he will not help the police because forensic medicine's objective is not crime detection and punishment. They have the duty to help in the dispensation of justice.[93] The only morally acceptable objection the forensic doctor can make when asked to contribute to crime investigation is that such an investigation amounts to injustice. In a just state, forensic medicine has to help the police.

At the investigation stage of a murder case it is morally important that only the perpetrator of the murder be arrested and questioned about the crime. It would be an injustice and an infringement, if not a violation of rights for an innocent person to be suspected, arrested and interrogated for a crime they did not commit. Here I am not suggesting that innocent people may not be justifiably arrested and questioned if there are limits placed on the length of detention and how they are treated. What I am suggesting is that forensic medicine helps investigators to at least reduce the chances of innocent people being held for questioning.

At the investigation stage of a capital murder, it is in everybody's interest that those who are not guilty of a crime should not be put in a position where they can be suspected of having committed a crime. So justice demands that crime detection techniques be improved, and the use of forensic medicine might be one of them. If forensic medicine can help in the detection of crime, and that is in the interest and well being of those who have a stake in society, it would be in accordance with the Gewirthean principle of generic consistency to involve the forensic doctors in the detection of crime. In Kantian terms, the state has the right to demand that its citizens help in the detection of crime, and such help is a duty.

FITNESS TO PLEAD AND STAND TRIAL

Once the right suspect has been arrested, it can be part of the medical profession's responsibility to help determine in a trial, whether the defendant was sane. I argue that doctors should be involved here because justice demands that only deserving criminals are punished, and sanity is important for one to deserve something. In Gewirthean terms, it is in the interest and well being of society that this is done.

The court has to determine to what extent they have to impute moral responsibility to the suspect and this also is helped by the psychiatrists and in some cases, physicians. The contribution by doctors includes the determination of sanity to stand trial and plead. In Kantian terms, people are morally responsible for what they did in accordance with their will. For an agent to act in accordance with his or her will, the person must be free. Freedom does not only mean that the agent is not compelled both externally and internally. It involves the agent being able to be rationally aware or understand the nature and consequences of his actions. In the case of a crime having been committed, the suspect has to be shown to have knowingly and willingly committed the crime. The state, whose duty it is to establish the suspect's moral responsibility for the crime, has the right to ask those who can help to do so as a matter of duty. Since only psychiatrists

[93] For example the Hippocratic Oath states: "3. I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and ***injustice.***" (emphasis added).

are the ones who can help the state to determine to some extent, what one willed in carrying out a certain act, they have the duty to help the state as a matter of urgency if justice is to be done to the suspect and the defendant.

This is related to Gewirth's view that morally acceptable institutions can create roles that may enhance the pursuit of people's interests and well being, which is their moral right. We have the moral right to have wrongdoers pursued by the justice system. This can mean the search and arrest of suspects. On the other hand the suspect has her or his moral right not to be punished for acts he or she carried out when a psychiatric patient, or when mentally ill. If determination of mental illness depends on psychiatrists, or other doctors, then they morally may have to take part in the trial stage of the capital punishment process. The interest and well being of members of society are catered for when criminals are arrested and tried, that of suspects when their sanity is determined, and when found to be insane, treated rather than punished.

SENTENCING STAGE

Once a prisoner has been found guilty, should the doctor give evidence that may influence the jury to sentence the prisoner to death at the sentencing stage? I argue that doctors should give evidence that may influence the jury to sentence the prisoner to death. They have the duty to obey the state, which is for justice. They do not have a patient-physician relationship with the prisoner and therefore are not bound by the demands of that relationship. They have the duty to tell the truth, and their involvement does not make them responsible for the process that kills the prisoner. They have the duty to assist the state in doing justice.

If one believes that medicine has nothing to do with justice, one may raise a moral objection to the effect that doing or saying something that may endanger the life of a human being is always wrong, as it is against the primary vocation of doctors, which is to save human life. But for the courts duly to sentence a guilty person to death is not the same as killing the person. The doctor only participates in the process that ultimately kills the guilty human being. He is not responsible for the process or even for its ultimately killing the prisoner. And he is acting in the morally justifiable role of assisting the judicial system. Still, in pursuit of the need to protect and save human life, the doctor could intelligibly refuse to give testimony when such testimony would endanger the life of the prisoner but testify when it is likely to result in a sentence other than death.

Is the doctor's duty to save human life paramount? Not necessarily. There are other duties that doctors have. Thus, whilst the doctor has the duty to save human life, or not to take it, they have the duty to do justice or not to stand on the way of justice.[94] What this means is that if the doctors' duty to save life conflicts with other duties, it may be

[94] One may ask where the duty not to stand on the way of justice comes from and whether it overrides other duties. It seems as if one would necessarily hold that if somebody has a duty to do justice, they simultaneously have the duty not to commit injustice. It is not far fetched to propose that doctors have the duty to do justice. At least even the Hippocratic Oath suggests so. One would also expect Kant to hold that doctors have the duty to do justice, as indeed every human being. The duty for the doctor to do justice would seem to override the other duties. If it is just for the doctor to perform his duties, then it is all right. But if performing his duties will result in some serious injustice, the doctor would presumably be bound to do what in the overall will be just.

necessary to forego the duty to save life. In the case of giving evidence that may result in the passing of a just death sentence, the doctor does not have to hesitate. A doctor giving evidence is not in a patient-physician relationship with the prisoner. At that point it is not his duty to save the prisoner's life. One of the duties of persons to others, according to Kant, is to tell the truth. As Sullivan states, lies are violations of "the dignity of humanity and are morally wrong"[95] So the doctor cannot refuse to give evidence when such evidence may result in the death sentence. He also has to ensure that he does not violate his duty to tell the truth. On the other hand, giving truthful evidence does not violate any duty, since it is no duty of the doctor to stop society executing deserving prisoners. It is not very clear why the medical associations do not object to doctors' involvement at the sentencing stage of a capital trial. It might be that the medical associations' silence is an acknowledgement that doctors have other duties besides saving human life and reducing pain. Such duties could be employer—employee contractual relations and importantly, the service to justice and truth seeking.

The overriding justification for doctors to be involved in witnessing against the defendant at the sentencing stage of a murder trial is that justice has to be done. Kant would argue that firstly the doctors have the duty to obey the state. In the case of a morally just state, it is obvious that if doctors are the only people who can help the state in certain respects they should as a matter of duty. Secondly, as just citizens doctors have the duty to participate in, and contribute to the administration of justice. It would be unjust to harshly punish anyone or to let a murderer get off lightly because medical evidence is lacking to determine the extent of a convicted murderer's moral culpability.

TREATMENT ON DEATH ROW

Once the prisoner has been sentenced to death, he has to await his appointment with the executioner. During the waiting, prisoners usually need medical attention. They should get this medical treatment because not to treat them would be inhuman and therefore a degradation of their human dignity. Prisoners should be given medication when they need it just as they are given food.

Prisoners are usually given medication without any moral debate. Death row prisoners are given food, clothing and other necessities for survival as well. They may even get better food and clothing and better medical attention than beggars and homeless people who are innocent of murder. One question is whether it is morally right that people who have committed heinous crimes should get such treatment when the innocent beggar gets less. It could also be asked whether it is morally right to expend resources on people who are going to be killed anyway rather than save them for other better uses such as poverty alleviation.

It may not be morally right that there are beggars and homeless people in society, and it may also be unjust that criminals get better resources than innocent people such as beggars. But that does not mean it is just to deny prisoners these resources. What is certain is that poor people have rights which prisoners may be denied, such as employment and freedom to do many things. But prisoners, by virtue of their

[95] (Sullivan, 1989:372) note 6.
Lies can also deprive someone of their rights according to Kant (1965:44).

incarceration become a responsibility to government or whoever has incarcerated them. The responsibility raises the duty to treat prisoners as human beings. That is, treatment of prisoners should not insult their human dignity. Denial of food, clothing and health is an inhuman treatment. Since even death row prisoners are human beings, they have the right to be treated humanely. That is why doctors are expected to treat death row inmates when they are ill, be it psychologically or physically. The fact that poor people do not have the resources they need is not ascribable to the fact that resources are used for prisoners. The issue of how resources should be divided between prisoner care and poverty alleviation would arise if the only resources available have to be given to either group. Now it does not seem to be clear that it is the case. So one would expect prisoner care by doctors as a minimum programme to maintain the human dignity that prisoners have.

DETERMINATION OF DANGEROUSNESS TO SOCIETY

Psychiatrists can be called either at the sentencing stage of a criminal trial or during the time when the prisoner is on death row to determine whether they could be dangerous to society if they did not get executed. It is in the interest of society and therefore just that psychiatrists determine whether prisoners would be a danger to society if the were not executed. They however have to be competent to make that determination.

The medical associations have objected to psychiatric determination of prisoners' future dangerousness on the grounds that such predictions are usually wrong and that they unjustly put prisoners at the risk of being executed. The argument is acceptable if psychiatrists are unable to predict future dangerousness. But the objection does not relate to the principle of prediction itself. That is to say, if psychiatrists were able to predict the dangerousness of prisoners accurately, there is no reason why they should not make the predictions. The fact that they are sometimes wrong in their predictions does not mean they never get it right. All that needs to be done is to emphasise the need not to make a prediction lightly. The prediction as to whether a prisoner is likely to be dangerous to society is important because society has to be protected as well as the prisoner.[96]

Kant does have room for the ruler to forgive the murderer if execution would lead to more injustice, or threatens to return the people to the state of nature. The ruler can do that as an act of benevolence and prudence based on the possible repercussions of execution. This happens normally when there are many people who were involved in

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[96] Kant (1965:108) believes that a sovereign can be unjust if he forgives a criminal by commuting his sentence or reducing it. However, there are cases when he can. Kant says, "with respect to a crime of one subject against another, he absolutely cannot exercise this right, for in such cases exemption from punishment ... constitutes the greatest injustice toward his subjects. Consequently, he can make use of this right of pardon only in connection with an injury committed against himself ... even in these cases, he cannot allow a crime to go unpunished if the safety of the people might be endangered thereby. The right to pardon is the only one that deserves the name of a "right of majesty."
It might appear that since Kant emphasises that murderers must be executed as a matter of the state's duty, there is no point in talking about the determination of prisoners' dangerousness to society. This is because for Kant, the prisoners should be executed anyway; in which case, whether they would be a danger to society in the end would not matter following their execution.

the murder. The solution is to exile them (Kant, 1965:104). In such cases it would be reasonable to determine prisoners' future dangerousness to society.

Here it would appear that members of society are taking care of their own interests and well being since dangerous criminals would threaten that. On the other hand, the prisoners might also benefit from this exercise since being found to be less of a danger to society may enable rulers to exile them if they have to follow Kant's advice.

FITNESS/COMPETENCE DETERMINATION FOR EXECUTION AND TREATMENT TO RESTORE COMPETENCE

Should doctors be the ones to certify competence for execution? And should they treat prisoners if they are judged to be incompetent? My answer to both questions is yes. Doctors must certify competence and treat prisoners to restore competence to be executed because it would be unjust to execute incompetent prisoners. Executing incompetent prisoners is failure to treat them as rational beings. It is treating them as mere means rather than ends in themselves.

What is important here is to ask what the moral implications of executing an incompetent prisoner are. Imagine that a two-year-old child happens to find a loaded gun. Thinking it to be one of the toy guns his father bought for him, he shoots and kills their neighbour. Supposing, as many people do, that the child cannot be held morally responsible for killing the neighbour, it would be immoral if the child was arrested, tried and sentenced to death. The same would hold if a severely mentally retarded old person did it. Even a full mentally alert adult person would not be held responsible both morally and legally for what he did not know. For example, if he accidentally stepped on a remote-controlled bomb detonator that killed some people. What is common in the three cases is reasonable lack of awareness of what the actions would result in. That is why it is important to determine the competence of a prisoner. In the case of death row inmates it would not be punishment anymore if they were to be executed when they were incompetent. It would be inflicting suffering on somebody who does not understand why it is done. It is a significant requirement that somebody to be punished understand to some extent, why they are being punished. This raises the question as to whether competence to understand punishment is required for punishment to be consistent with retributivism, given that in retribution one is punished for what one has done.

It is the case that for a just punishment to be meted out to a murderer, he should be found guilty after due process. This includes establishing his sanity as said above. After being found guilty of murder and sentenced to death, the prisoner would retain his culpability as long as he is sane. The culpability seems to be lost or at least suppressed when he loses his sanity. Punishing an insane person would be like inflicting harm on someone who has not done anything to deserve the infliction of harm.

The fact that an incompetent prisoner has to be competent to face his responsibilities may mean that he has to be competent in order to enjoy full humanity. Mental deficiency means in Kantian terms that the agent lacks autonomy or personhood (Hill, 1992:87). The prisoner's lack of understanding when he is incompetent means that he is unable to know what the difference between good and evil is, and he is unable to make a

connection between the punishment and his actions. This actually shows why there cannot be punishment for an incompetent person.

Since it is morally wrong to punish an incompetent person, it is better to make him competent if that is possible, or wait for the return of his competence, and then punish him. The other option is to abandon the punishment, but according to Kant, the punishment of wrongdoers is a categorical imperative. Justice would not be served if the guilty are left unpunished. As Sullivan (1989:243) explains:

> justice may be mitigated by benevolence, but the criminal still owes *society* a strict debt to restore the reciprocal contractual relationship between obedience to the law and benefits received from living under the law. When, but only when, guilt and the proper punishment have been determined does Kant permit the introduction of utilitarian considerations based on experience, for example, the deterrence value of punishment and its contribution to the rehabilitation of the lawbreaker.

The objection to doctors treating incompetent prisoners for execution competence is based on the belief that execution itself is wrong. If capital punishment is not wrong, it is difficult to see what could be wrong with doctors treating prisoners for execution competence. It would appear to be expected that if the execution of incompetent prisoners is a moral wrong and capital punishment is not, doctors should treat prisoners for execution competence. It is in view of this Kantian argument that one would see no problem with doctors determining prisoner execution competence and treating them to restore it if necessary.

For the medical associations to reject doctors' determination of prisoner competence for execution, or to reject treatment to restore the competence, they have to show what is morally wrong with such involvement. They have to show the moral illegitimacy of the state's claim to have the right to punish by execution and expect those who are capable to help in the process. But this is the issue that they do not want to be involved in.

TRANQUILLISATION

I argue that if tranquillisation affects the rational ability of the prisoner so that he does not understand what is happening during his execution it should not be allowed because the prisoner would be trying to flee from his responsibility of facing up to his punishment. If however, tranquillisation enhances the prisoner's dignity it should be allowed as a matter of duty. If tranquillisation does not enhance the dignity of the prisoner, but enhances that of the executioners, the prisoner must be tranquillised even if he does not want because he is responsible for the situation in which he finds himself and others.

Tranquillising the prisoner may probably raise an objection from a Kantian. This is because if the tranquillisation makes the prisoner less conscious of his impending execution it means that he is less autonomous and therefore has less dignity. This would hold both for involuntary and voluntary tranquillisation. Tranquillisation would seem to assist a brand of moral cowardice whereby the prisoner is afraid of facing up to the challenge of bearing the consequences of his punishment. The question then is whether it is morally acceptable for the prisoner to be helped in his flight from the responsibility

of facing execution consciously. One would say that it is nobody's duty to help other's in flinching from their responsibility; therefore the prisoner should not be tranquillised when he asks for it.

Even if tranquillisation benefits prisoners in a certain way,[97] it is not necessarily morally wrong to desist from it when the prisoner wants us to. The insistence on tranquillising the prisoner against his will for his own good would amount to unwarranted paternalism.[98] It would be unwarranted because one would not seriously argue that if the prisoner is prepared to bear the pain of execution, then somebody is doing a moral wrong in allowing them to.

Tranquillisation would be objectionable if it indeed undermined the dignity of the prisoner. If in fact tranquillisation helps to maintain the prisoner's dignity, one would accept it probably as a matter of duty since the most important thing for Kant is the respect of human dignity both in the prisoner and in every other member of society. If execution without tranquillisation dehumanises other members of society in some way, matters might stand differently. This could be the case even if it undermined the dignity of the prisoner. Probably Kant would accept that if the human dignity of both the prisoner and society were threatened, the better thing would be to safeguard that of society rather than the prisoner's. This is because the prisoner is responsible for the situation he finds himself and everyone in.

LETHAL INJECTION

Lethal injection should be allowed because there is a Kantian argument, which is that some people are better off dead than alive. A prisoner is such a person since he has an ethical duty to die and the state has the judicial duty to execute him. Doctors must execute prisoners by lethal injection because science has developed to the extent that it can help the state carry out its moral duty to execute prisoners with dignity. Doctors or people with medical knowledge are better qualified technically than other people to do this. Their involvement is a duty because they not only have the duty to desist from impeding the state in carrying out its moral obligation according to Kant, but they have the duty to help the state.

The history of capital punishment shows the indignities suffered by both the executioners and the prisoners. Execution methods such as quartering have been particularly painful for the prisoner. Such methods are the ones that a Kantian would not agree with as they degrade the prisoner.

The insertion of a catheter; injecting the prisoner with the lethal agents; in short, executing the prisoner by medical means, is objected to on the grounds that killing is against medical ethics.

As Pence (1997:31) puts it:

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[97] Tranquillisation should benefit the prisoner in a way that is connected to his humanity, if that is to be a Kantian justification for it. If tranquillisation benefited the prisoner by enhancing his dignity, and execution without it had the opposite effect, there might be a duty for those executing the prisoner to ensure that he is tranquillised, and probably even against his will.

[98] Kant is against paternalism (Rosen, 1993:197 & Kant, 1965:82).

> the idea that the role of physicians does not permit killing is sometimes expressed in the saying that, 'physicians should be healers, not killers.' This claim is frequently made, and is explained in the historical survey above about what patients want, this claim has been a good directive for most of human history. Today, however, it begs the questions against patients by assuming, contrary to much evidence, that all patients do not want their physicians to help them die.

Just as physicians could help patients die with dignity, they could do the same with death row prisoners.[99] What is of importance however is the challenge posed by this point to the traditional view of medicine. The question is, has medical science developed to such a point that it can be used for penal justice in a way it has never been done before? I suggest that medical science has developed and that development can be further utilised in other areas of human life. In other words, if doctors have not been required to play different roles, even apparently conflicting ones before, it does not mean they should not be required to. There are many duties that people have and which sometimes appear to conflict.

Medicalisation of capital punishment is a call to recognise that medical knowledge can be put at the service of the execution. The service of the execution by the medical doctor enhances the prisoners' human dignity, or at least it reduces the indignities experienced in other methods of execution. This is in accordance with Kant's call for execution but with special care to ensure that the executed do not lose their human dignity. What is important and accords with Kantian moral philosophy is the idea that someone can be better off dead and that they thereby become duty-bound to die. This of course raises the related questions of when and how the person should die, where and who should kill them.

WHO SHOULD EXECUTE?

Who should execute the prisoner? It is the state that should execute the prisoner. The state does this by delegating somebody to do it on its behalf. That is the creation of a role whose holder has the duty and authority to execute the prisoner. My argument is that since the state has the moral authority to execute the prisoner, it has to the right and duty to improve the methods of execution. Since lethal injection is the best method of execution which can ensure the maintenance of the prisoner's dignity, doctors or people with medical knowledge should execute prisoners by lethal injection. They have the duty to help the state in its endeavour to do justice.

The problem with the role of executioner is that sometimes human dignity is not enhanced by its methods. For example, hanging, firing squad, quartering, gassing and so on. It is indeed one of the objections against execution that some of the methods are "inhuman." That is, they debase the human dignity of the prisoner. This should not be allowed since as Kant points out according to Hill that the primary principle is that human beings be treated as ends in themselves never merely as means. "These principles say that one must seek to preserve, develop, exercise, and 'honor' rational

[99] One may object that capital punishment prisoners are not patients and therefore should not be treated the same way as patients. What is of importance here is the idea that both patients and prisoners are persons with dignity. If doctors can do something to maintain that dignity, they should even if the doctors do that in different roles—doctor-patient versus agent of the state-prisoner.

agency in oneself and to respect it in other human beings, no matter how immorally and irrationally they may behave. To preserve human life per se is not among the principles" (Hill, 1992:204). That is why it is legitimate that methods of execution are reviewed and new ones tried out with a view of adopting the best ones. This is where doctors come in. It seems that the best methods of execution at the moment that can enhance human dignity by limiting pain are medicalized methods.

So the answer to the question "who has the duty to execute the prisoner?" may be "the doctor or someone with medical knowledge." The doctor's duty to execute the prisoner by the medicalisation of capital punishment does not only arise because they are members of society which has the duty; they have the duty specifically because medicalisation in particular may be the best way of carrying out the duty. If prisoners suffered unduly because doctors refuse to help in the execution process, that might be morally wrong for "Kant makes it clear in his later writings, treating a person's humanity as an end in itself requires more than refraining from acts that would exploit the person as a mere means. Indifference to a person is also forbidden, and positive assistance may be required" (Hill, 1992:202).

SOME PEOPLE ARE BETTER OFF DEAD

Here I argue that some people are better off dead than alive. A prisoner is such a person. From a Kantian we can conclude that a murderer has an ethical duty to die from the fact that as an honourable person he should understand why he should be killed. Even if the prisoner has no honour and would flinch from his ethical duty to die, the state has a judicial duty to execute him.

It is expected that all human beings will probably die some day. Hardwig (1997:53-65) observes that sometimes death comes at the wrong time. It either comes too soon or too late, and when it does, there is a tragedy to the one who dies, their relatives and friends. One can easily imagine a situation when somebody dies suddenly and unexpectedly because of an accident. Generally accidents are expected to occur, but when they do, there is a certain surprise about them. In that case death would have come too soon. The friends and relatives of the deceased would be shocked, as they would have wanted to continue associating with him and the person would have been a loser in that he would have preferred to continue living. On the other hand, death may be delayed and come later than it should, thereby causing a lot of distress and emotional torture to the subject and those associated with him. For example, there are diseases that can make their victims want to die but without success unless some kind of intervention took place. So prolonged suffering would result. This raises the question, "is there ever a situation whereby somebody would be better off dead than alive?" Hardwig thinks situations of disease can raise this question and result in a positive answer. Some diseases can make the sufferer think it is better for them to be dead than alive. An example of such diseases is some kinds of cancer, which slowly eat away the victim until his death that comes after prolonged pain and suffering. The quality of such patients' lives becomes valueless to themselves and their relatives. Doctors, friends, and relatives of such patients also get to the point when they experience the life of the patient as nothing positive at all. In short, the patient's life becomes something of

negative value. Such diseases can reduce the patient to something less than a human person[100] and people may even wonder whether any human dignity remained if the patient deteriorated beyond a certain point. For example when the patient can no longer control their digestive system and the carers are emotionally, physically and aesthetically upset by the condition of the patient. When such diseases strike, it seems many people may agree that the patient would be better off dead especially when they are more or less certainly going to die from the affliction. So it is plausible that sometimes there are situations when people are better off dead than alive. This may be the case from either the patient's point of view, and, or from an objective one. There can also be agreement about this.

Kant (1965:85) might not endorse suicide,[101] and maybe, by extension, he would deplore euthanasia. Suicide is violation of human dignity because the agent would be misusing her or his humanity. It is also considered to be treating humanity in oneself as a mere means rather than an end.

One can advance a Kantian point of view to argue that certain people can be better off dead than alive. Kant gives the example of a soldier who would not like to live with the stigma of being labelled a coward and would therefore challenge others to an ultimate duelling match.[102] If there is a situation in which the dignity of a person would be undermined as long as the situation obtains, and such indignity would only end when the person died, or put another way, if the indignity would continue as long as the person lived, it would seem to be better for the person not to be alive. The person would be better off dead than alive. Imagine a person who falls into the hands of a hardened criminal who locks him up in a secret location where he inflicts all sorts of cruel and dehumanising things imaginable every day of his captivity. Once this goes on to a certain extent and intensity it seems many people would agree if the victim felt that he were better off dead than alive. If so, it appears a duty would naturally arise for the person to kill himself or to be killed if he cannot be resurrected or saved from the situation.

Take a situation where a loved one is trapped under a big boulder and it is clear that he would die but only after suffering pain and other indignities. It might be one's duty to just kill him there and then. So the situation would have given rise to the duty on the subject to kill the loved one. That is, if he could not kill himself even if he knew he should die. So the loved one would have the duty to kill him. This answers the questions; do some people get into a position when they are better off dead than alive? Do some people have the duty to die, and if they do, who should kill them?

We can apply this to a death row prisoner. In Kant's thinking, when a person has committed a crime, it is not just a duty on the part of others to punish them but in a way

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[100] A person as distinguished from a mere human being whose death could raise less of a moral problem if any than the former.

[101] The reason for rejecting suicide is that it is not consistent with universal laws of humanity. It cannot be universalised.

[102]For example "In one passage (M.M. 336-37) Kant questions the state's political right to invoke capital punishment against a mother who murders an illegitimate child to preserve her honor, since the child 'crept surreptitiously into the commonwealth (much like prohibited wares)' and laws forcing the mother to acknowledge the child would have the effect of disgracing her. Kant thinks there is a parallel between this and the example of a military officer who kills another in a duel to preserve his honor. But his contentions, which certainly sound morally odd today, also raise the historical recognition of those demands within historical cultural beliefs" (1989:361), note no.25.

it is the duty of the criminal himself to see that he is punished for the wrong he has done. Christine Korsgaard says, "one of the appealing things about Kant's ethics ... is that moral thought is seen as arising from the perspective of the agent who is deciding what to do. Responsibility is in the first instance something taken rather than something assigned" (Korsgaard, 1996:189). He certainly does not believe in the adage "better a live rat than a dead lion." This means as an honourable person who has committed the crime of murder would not want to continue living because of the ultimate crime they have committed. An honourable person behaving morally would realise from the moment they have committed the crime that they deserve nothing but execution and they should not expect anything less or more. They would actually confess the commission of the crime and not try to escape its consequences. They would not be satisfied if society tried to treat them as something other than murderers, and would demand the appropriate response from society. It appears accepting deserved death by execution might enhance one's dignity. On the other hand, Socrates probably enhanced his dignity by accepting his death rather than trying to flee as his friends advised. In a way he respected the autonomy of his killers by not denying them the opportunity to commit their crime against philosophy and human dignity whilst he obeyed the authorities and ensured that he did not do anything unlawful. In Socrates we see that a Kantian would violate no law, which is a duty,[103] and one who is prepared to do his part of duty in spite of the immoral behaviour of others.

When the murderer killed his victim he negated his own civil personality. He imposed a duty on everybody legally to punish his wrongdoing. This is so to the extent that if society did not know about the murder, he would be duty-bound to reveal it if he is an honourable person (Kant, 1965:103). If society were not prepared to do anything about the murder, the honourable murderer would be morally troubled. By murdering his victim, the honourable murderer has imposed a duty on everybody to see that he is executed. It would be morally better that honourable murderer be executed than to continue living. Society would be disrespectful of our honourable murderer if they did not let him face the consequences of his rational actions—execution. So we may say that from a Kantian point of view a murderer is the sort of person who is better off dead than alive. Here I have to point out that the honourable murderer's duty to die is not a judicial duty. It is an ethical one—that is what the murderer must have as his end. But then personal ends cannot be ruled by society. This means the state's duty to execute the murderer must come from somewhere else rather than his personal morality.

We must remember that Kant sees the state as the best available means of protecting people's rights. As penal institutions are a part of that goal, they have the duty to guarantee justice. In this case justice can only be done by punishing the criminal who, on committing a crime, cast himself out of society thereby incurring a debt that can only be exacted by the state through penalties. So in short, the state has the duty to punish the murderer because it is just to do so. He has disobeyed the law and he should be punished.

I have talked about the "honourable murderer" who would accept and understand his duty to be executed for his crime. What can we say about a dishonourable murderer? Does he have the duty to die as well? A duty does not arise simply because we

[103] "The mandate 'Obey the authorities;' is an unconditional moral as well as civil injunction" (Sullivan, 1989:244).

recognise it for what it is. We may have duties which we do not accept as duties or which we do not know to be our duties. If part of respecting human dignity is the acknowledgement of an autonomous decision, why should we not respect the murderer's decision to continue living in spite of having committed murder and refusing to accept that it is his duty to die rather than live dishonourably? His behaviour will not be tolerated because the decision to remain alive is a refusal to accept guilt. He has already accepted to abide by the law, including penal law. Further, if the murderer reasoned well, he would understand and accept that he could not be rational and hold at the same time that he should not be punished by execution for committing murder. Rational people are able to understand this. If we agreed with him, we would be acting irrationally. Autonomy consists in understanding this principle—people should not be treated merely as means but as ends in themselves. That includes respecting their dignity and right to live. He refuses to accept this by murdering. The murderer should understand that if it is not right for him to be murdered, it could never be right for him to murder his victim who has the right not to be murdered. If it is just that a murderer should be executed for murder, it follows that I should be executed, if I happen to be the murderer. It would be irrational for the murderer to argue that murderers should be executed but not him unless he can give a good reason why he should be treated differently from other human beings. So it seems to follow that the dishonourable murderer should have the same treatment, duties and rights that the other has. So the dishonourable murderer would be executed not because he is behaving an ethically by not adopting as his end, the view that he should willingly hand himself over to be punished for his crime. He would rather be punished because the state has the judicial duty to uphold justice, which can only be done by executing the murderer.

ORGAN DONATION

I argue that even though Kant would probably not accept prisoner organ donation there is a basis however, for the advancement of a Kantian argument in favour of organ donation. The Kantian ideal of personal moral development can be realised when the death row prisoner is persuaded to donate his organ so that he repays the life he has taken by saving one through organ donation. On the basis of the Kantian idea of desert some prisoners might deserve more than just execution. So in order for the punishment to fit the crime, the prisoner might be required to give his life and save others. This would mean that not all prisoners should be forced to donate their organs after execution.

Prisoner organ donation may not be acceptable for a Kantian on the grounds that punishment should not be for the benefit of the state, and that there should not be benefits from execution besides justice. I claim, however, that prisoner organ donation may be seen as the willingness by a prisoner to pay back in kind what they have taken from society. Since they have taken life, it is only just that they should endeavour to give it, in this case by contributing to the life saving procedure of organ donation. In a sense the possibility of organ-donation gives the murderer an opportunity to right their wrong. If the prisoner did not subscribe to this view, he might be persuaded to. One can actually go on to suggest that voluntary prisoner organ donation would not only be

allowed but be a mandatory duty.[104] This accords well with the Kantian idea of personal moral development as a duty and the right by society to respect a rational being by demanding that they carryout their duty.

Kant probably would not readily accept the benefits of execution for he says about utilitarian considerations relating to capital punishment:

> the penal law is a categorical imperative, and woe betide anyone who winds his way through the labyrinth of the theory of happiness in search of some possible advantage to be gained by releasing the criminal from his punishment or from any part of it, or who acts in the spirit of the pharisaical saying: 'it is better that one man should die than that the whole people should go to ruin.' For justice perishes, there is no further point in men living on earth. What then are we to think of the proposal that the life of a condemned criminal should be spared if he agrees to let dangerous experiments be carried out on him in order that the doctors may gain new information of value to the commonwealth, and is fortunate enough to survive? A court of justice would dismiss with contempt any medical institution which made such a proposal; for justice ceases to be justice if it can be bought at a price (Reiss & Nesbit, 1991:155).

The quotation above does not relate to organ donation, obviously, but what is important about it is that it talks about punishment and justice. Somebody may use the ideas expressed in the passage to argue that justice, not that it is beneficial, demands capital punishment. It is not just that people harvest condemned prisoners' organs even if that would be beneficial to society. In other words, just as justice would demand the execution of murderers even if there were no benefits, justice demands abstinence from harvesting condemned prisoners' organs.

This statement however had better not be seen as a conclusive argument against prisoner organ donation. The emphasis seems to be more on the objection to Utilitarianism than to the idea of benefits from capital punishment as such. It may be that it is good that there are benefits accruing from capital punishment, but the benefits cannot and should not be used as a justification for the practice. So one would not necessarily reject organ donation by condemned prisoners because of this statement.

An honourable murderer who regrets his murderous activity might want to repay society the loss that it incurred in the murder and the only palpable and meaningful way to do that is to attempt to save live. In offering their organs for donation after death the prisoners would be doing their duty of paying back what they have taken even though it is in kind. It could be objected that by being executed the murderer would have paid with his life. If he were to give his organs in addition, would that not be exacting more than the prisoner has taken from society? Kant himself has accepted that we are not able to make a clear determination of the equality of crime and punishment. But we are able to make a reasonable estimation of the two all the same (Kant, 1965:101). It is easy to imagine a situation where a murderer did not only kill his victim but mutilated him in some other way, including those who are related to the victim. In such cases the imposition of death alone would not be enough to pay for what the criminal has done. In such cases the donation of the prisoner's organs would address the problem.

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[104] One may question how the persuasion suddenly becomes a duty, and what would happen if the prisoner would not be persuaded to accept that he has the duty to help save others' lives. If capital punishment is a payment in kind as Kantians hold (in the case of execution for murder), it might be more appropriate to demand that the prisoner **give** a life rather than ***give up*** his life. The most approximate way of giving a life is by helping to save one, and organ donation would be near that mark. So instead of demanding the prisoner's life (execution), society could demand his help in saving a life (organ donation).

It is clear that the prisoners cannot bring back their murder victims, but in offering their organs for donation they make it possible to save other human lives that could otherwise be lost to disease. If this reasoning is correct, one would expect that a Kantian could seriously consider this option as one of the best, that is, if there is no loss of dignity, either of the prisoner or that of other people. In accepting prisoner organ donation one would not be arguing that murderers should be executed so that they donate their organs to needy patients. The argument would rather be that it is morally just that murderers be executed. The process of execution has other consequences such as the imposition of the unpleasant duty to execute. On the other hand, the process could have beneficial consequences such as organ donation. This would suggest that at least voluntary organ donation by prisoners should be allowed.

If voluntary organ donation was to be allowed for the above reason, why should the prisoners not be persuaded to donate their organs, and if they refused, forced? Prisoners can be forced to donate their organs after execution because it can be just to do so. Justice would not have to depend on the honourable nature of prisoners who acknowledge that they have to pay back to society what they have taken. The state, as the protector of human rights would have the right and duty to exact the desert from a criminal such as a serial killer.

It seems that it might be possible to reason with the prisoners and show them why first of all they have to be executed. It seems Kant would not have problems with us persuading prisoners to understand why they should be executed. If that is the case, why not persuade them to donate their organs? I think to be consistent, if prisoners refuse to accept execution we still go on to execute them, and we should do the same in the case of organ donation if it can be done without violating human dignity.

If organ donation would be based on the gravity of the murder and all the important injustices associated with the murder, it would mean that some murderers would not qualify to donate their organs. For example, if the prisoner murdered a notorious robber who has no friend or relative, in the least painful way possible, on what basis would he be expected to donate his organs? Most probably he would not be treated justly if he gave his life plus his organs for taking the life of the notorious robber. He could donate his organs on the basis of beneficence. But then that could not be exacted from him as to be benevolent is not a categorical imperative.

CHAPTER 7

UTILITARIAN ARGUMENTS FOR MEDICALISATION

There are thirty-six capital punishment territories in the United States. The five methods of execution are firing squad, hanging, lethal gas, electrocution and lethal injection. Of the thirty-six states, only two use firing squad, three use hanging, five use lethal gas, twelve electrocute and twenty-five use lethal injection. All the states use one or two methods of execution but not more. There are only eleven states that do not use lethal injection. It is most probable that many more states will resort to lethal injection as more and more reject the first four methods. In short, there is a tendency towards lethal injection.[105] This tendency means the medicalisation of executions. Trombely (1993:81) writes:

> just as the electric chair was invented as a modern and 'humane' replacement for hanging, so lethal injection has emerged, a hundred years later, as the 'humane' execution method of the late twentieth century. Lethal injection has become popular not so much because it works *better* than other methods of execution, all of which leave the condemned person equally dead; it has become popular because it is, first and foremost, a medical procedure. It has the appearance of being more 'scientific' than shooting, hanging, gassing, or electrocution. It is clinical. The equipment includes intravenous lines, prescription drugs, a hospital gurney, medical technicians, doctors, and an execution protocol in which the condemned person is sedated prior to being executed. With lethal injection, there is no obvious damage to the inmate. The theory is that the inmate simply 'goes to sleep.'

In this chapter I am arguing that the trend towards medicalisation of the death penalty should not only continue as long as executions are carried out, but that doctors should be actively involved as well. There is a utilitarian case for the medicalisation of capital punishment. I base my argument on Mill according to whom the end of every human action is the attainment of happiness. The best way to achieve this happiness is the application of the basic principle of morality, which is that the morality of actions depends on their promotion of happiness. I argue that the medicalisation of capital punishment will promote happiness, and therefore doctors must be involved. To do this I will start off with an account of Utilitarianism and then I will apply it to the different stages in which I think doctors should be involved. The stages I will deal with are: the investigation of a capital offence, medical determination of a suspect's fitness to plead and stand trial, medical participation in a capital trial, prediction of the prisoner's future dangerousness to society, execution competence determination and restoration,

[105] American College of Physicians et.al. (1994), Table 1. See also Curran, & Cascells (1982:1532-1533).

tranquillisation, subjugation of an inmate by medical means for execution, lethal injection and related preparations, organ donation and medical certification of death.

UTILITARIANISM

Before I delve into this debate it seems to be in order for me to give a short account of Utilitarianism. I am relying on the version advanced by John Stuart Mill. According to him, Utilitarianism is "the creed which accepts as the foundation of morals, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure" (Mill, 1991:137). "Pleasure" or "happiness" covers more than what might be thought. When the individual pursues her or his own happiness or pleasure, he or she is promoting the general good, unless that individual's pursuit of the pleasure hurts some other people (Mill, 1991:150).

When there is a conflict between an individual's interest and that of others, "utilitarianism requires him to be as strictly impartial as a disinterested and benevolent spectator. ... utility would enjoin ... that laws and social arrangements should place the happiness, or (as speaking practically it may be called) the interest, of every individual, as nearly as possible in harmony with the interest of the whole" (Mill, 1991:148). This is required, not only because the individual's happiness is intertwined with that of the whole society, but also because every individual should count equally. Every individual is therefore duty-bound to live by these terms (Mill, 1991:154-165).

One can deduce from the above that there are moral rights and duties. The individual has a moral right to pursue his happiness or pleasure, to avoid the privation of happiness or pleasure and the duties to pursue those pleasures that are of higher quality than others, and in so doing, to promote the happiness and well being of the whole. He has the duty not to injure others in the process of pursuing his own interest. Society has the duty to protect the individual's rights because that is expedient or useful, not only for the individual but also for the society as a whole. "Duty is a thing which may be *exacted* from a person, as one exacts a debt. Unless we think it may be exacted from him, we do not call it a duty" (Mill, 1991:184). Society may not decide to exact a duty from someone if doing so would impinge upon the interests and rights of others. If the overall consequences are the injury to a majority of people society ought not to exact the duty. But when society does exact the duty from an offender, he has no right to complain.

Morality consists of two types of duties. Perfect duties that give rise to rights. Examples are obedience to the law, behaving justly and morally, not hurting others and so on. Imperfect duties include virtuous behaviour, love of others, friendliness and so on. They are laudable and the individual is free to do them if he chooses, but would not be punished for not doing them. It is in the exercise of rights and carrying out duties that the question of justice arises. It should be seen in the context of society—political organisation. The law is not the criterion of justice, but it is an instrument, a useful one, with which society tries to protect moral rights and exact duties. That is why it would be inexpedient or morally wrong to disobey laws—importance of the rule of law.

Justice is related to desert. People should get what they deserve whether that is evil

or right. They deserve good when they have done right and evil when they have done wrong. "Injustice consists in taking or withholding from any person that to which he has a *moral right*," (Mill, 1991:179) and "justice implies something which it is not only right to do, and wrong not to do, but which some individual person can claim from us as his moral right" (Mill, 1991:185).

If we relate the above theory to the case of penal institutions, we may note that they are important in safeguarding and promoting the happiness of at least the majority of the people. They do this by not only punishing criminals but also by ensuring that it is done in a just manner. Punishment is important for the utilitarian because it deters crime, and obviously, the less crime there is the more likelihood of people being happy. If a particular punishment does not promote the happiness of people then it should not be meted out. The importance of justice is that in addition to being the morally right thing to do, it promotes happiness more than injustice. If an act of justice did not promote happiness, the utilitarian principle would demand that it not be done. We can imagine a situation where an individual committed a crime thereby deserving punishment. But if the punishment of the individual would result in riots and deaths, the utilitarian would say that the better policy is not to punish him even though it accepts that he deserves punishment. Think of a famous personality who has been convicted of rape. The law states that he should not be allowed into a certain country. If his entry into the country would promote the happiness of more people than the strict application of the law, it would be better that he be treated as a special case. Here we see that the law is not applied because it does not achieve its intended purpose—the attainment of the happiness of the most people. This does not imply that when something promotes the happiness of the greatest number of people it should be allowed even if it is unjust. The assumption is that usually injustice does not actually promote the greatest happiness. But for the exceptional cases where injustice can promote happiness in the long run it can be acceptable. This is because happiness is the end of human action and therefore should be pursued.

If we apply the theory to crime, we find that the individual has committed a moral wrong by committing a crime. The commission of a crime is a reduction of the amount of happiness in the society. The criminal has abrogated his duty to desist from interfering with people's right to pursue their own happiness. This duty can and should be exacted from him if doing so is not going to violate the rights of many others. In fact, exacting the duty will uphold the principle of rule of law. That is very expedient for the survival of society. So when society exacts the duty from him, he should not complain.

As for how the duty can be exacted from the prisoner, punishment is one of the ways to do it, if that is what he deserves. This is because justice demands punishment that is proportional to crime according the principle of desert. Retribution, tit for tat, good for good and evil for evil is a necessary tool of justice. This is "to prevent the just principle of evil for evil from being perverted to the infliction of evil without that justification" (Mill, 1991:198).

Natural justice would demand that people be told the consequences of their actions, and that when they are given their just deserts there should be impartiality. That is what a criminal could get when he has committed a crime, for,

> if it is a duty to do to each according to his deserts, returning good for good as well as repressing evil by evil, it necessarily follows that we should treat all equally well (when no

> higher duty forbids) who have deserved equally well of us, and that society should treat all equally well who have deserved equally well of it. This is the highest abstract standard of social and distributive justice; towards which all institutions, and the efforts of all virtuous citizens, should be made in the utmost possible degree to converge. But this great moral duty rests upon a still deeper foundation, being a direct emanation from the first principle of morals, and not a mere logical corollary from secondary or derivative doctrines. It is involved in the very meaning of Utility, or the Greatest Happiness Principle (Mill, 1991:198).

The way the medical institutions and the justice system should relate is by the two promoting justice. Let us suppose that the medical institutions pursued their own goals without any regard to the demands of justice. That would result in disquiet in society because society's happiness is promoted more by justice. The relationship between the penal institutions and the medical institution has to be governed by the same principle of Utility. The moral rights of people to pursue their own happiness without interference as long as they do not interfere with others' is not protected by the medical institution to the same extent that the justice system does. So in case of conflict between the medical institution and the justice system the latter should prevail. This is not only because justice will be promoted, but also that happiness will be guaranteed. This means if an act promoted the interests of medicine but did not promote justice there would be a problem. People would be unhappy when they feel that injustice has been done. Usually the medical professionals do not make it their concern to ensure that the individual's and the society as a whole's interests are consistent with each other. This is important, as it is the best way to ensure the happiness of the many. The state through the justice system does this. That is why the state must be more primary than the medical institution.

The medical institutions have to promote justice, according to the Millean conception of morality. This is made possible by society applying the Principle of Utility. Thus, just desert demands that people be punished in proportion to the gravity of their crime. If it is in the interest of society to apply this principle, they should. A criminal owes society, so it can demand the debt from him—punish him. The medical institution is a morally right one in so long as it promotes the interests and well being of society. The best way to do this is to apply the Utility Principle. What this means is that the medical and legal institutions must come together to pursue the same goal of promoting people's happiness by punishing wrong doers. It would be a moral wrong if people were not happy as a result of social institutions not co-operating in the pursuit of the important goal of crime prevention through deterrence. The individual doctor, as a virtuous citizen whose interest and well being are founded on the application of the rule of law for example, must help society to realise its goals. One of the ways to do this is by their co-operation with penal institutions.

I will examine the points at which the doctor can be called to participate in capital punishment beginning with the trial stage. A capital trial is some distance away from execution. There are many things that do happen between the trial and execution. There is also a time lapse. The implication of such a gulf between the two events could be that participation in one is morally different from participation in the other. That is debatable, but what is of importance for our purposes is the definite connection between trial and execution, and the first point of possible contact in the process of, or that culminates in execution. The moral importance of a capital trial is that it is the

determination of guilt which once established, settles the question of whether capital punishment should be meted out or not.[106] Doctors have been requested to give evidence in capital trials. Physicians can help to determine whether a certain disease afflicts somebody to the extent that it could affect their legal responsibility. Again, "psychiatry has become established as a medical speciality since the last century and psychiatrists during this period have achieved the status of expert for the purpose of assisting the law in performing its role" (Bluglas, 1990:169). Further, "Forensic Psychiatry is concerned with the assessment and treatment of mentally disordered offenders, the provision of psychiatric evidence to the criminal and civic courts and the application of the law to psychiatric practice" (Mason, 1995:391).

INVESTIGATION

I now turn to medical involvement with legal institutions in general and the capital punishment in particular. Forensic medicine can help the police to pin down a criminal. How can this be justified given that the arrest and subsequent trial of the suspect might lead to his execution once found guilty? Is this not contrary to the aim of medicine, which is to save life? This is a morally important question for a utilitarian to answer because it is about the best interests of the individual and society. It is about whether a morally right institution (medicine) should do things that appear to contradict its goals (participation in the capital punishment process). If it is in the interest of society to have medicine, which aims to save life, it would appear to be inconsistent to involve the institution in activities that kill. If it happens, what is the moral justification? For a utilitarian the question is, does such behaviour promote utility? I think it promotes utility. This is because every rule has an exception. Generally medicine must promote the health of people, but at times it might be expedient not to do so. By expediency Mill does not mean mere convenience. In the case of saving the life of a potential murder convict, other factors have to be taken into consideration—justice, rule of law, fair warning, deterrence, fairness and impartiality. Whilst it may be beneficial to save the lives of everybody, it is not necessarily so if it involves injustice. The risk of having the prisoner executed is less than the risk of social disintegration following the collapse of the legal institutions, which can happen when there is injustice. So to preserve justice, the legal system and social coherence it is necessary to make an exception to the rule that institutions should pursue their goals—medicine pursuing healing. This is necessary because it will bring more happiness to the highest number of people.

The fundamental question for the utilitarian is what the medical institution itself is for. Medicine is for the preservation of health. What justifies it ultimately is that it is in the interest of everybody that there be medicine. If the existence of medicine does not benefit the majority of people, or help in the injury of many, it has no right to be there—society has the moral right to get rid of it in self-defence. Medicine is detrimental to the interest of society if it strives to preserve the health of some people at the risk of perpetrating injustice. Their refusal to participate in the justice system violates the society's right to promote justice.

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[106] There is another stage in the legal process following the establishment of guilt—sentencing stage. The point is that the sentencing stage itself depends on a successful prosecution—guilt must be proved.

The investigation of crime is in the interests of the majority of people including the suspect. Justice demands desert, and therefore there is need to establish guilt so that only the guilty can be punished. The proper and sufficient gathering of relevant information can only do this. So it is the duty of those who have the knowledge to render their service to the system, including doctors.

Proper crime investigation has beneficial consequences for society. For instance, when people know that the application of the law permitting forensic evidence will enable the police to investigate crime more easily and efficiently, they have confidence in the justice system and feel more secure. This follows because would-be criminals are deterred from committing crimes, thereby resulting in less crime. Medical co-operation in the investigation of crime sends a clear message to criminals that more forces have combined to fight against them. The efficient crime detection and investigation helps the courts to establish guilt fairly.

MEDICAL DETERMINATION OF SUSPECT'S FITNESS TO PLEAD AND STAND TRIAL

Another stage on the way to prisoner execution where doctors get involved is when determination has to be made as to whether the prisoner is mentally and physically fit to plead and stand trial. Very few people, if any, object to doctors being involved in the determination of fitness to plead and stand trial. Doctors should be involved in the determination of the suspect's fitness to plead and stand trial. This is because to punish insane and ill people is unjust and is therefore not likely to promote happiness. Distinguishing between sane and insane suspects helps to deter crime. Doctors have the duty to help the state deter crime by their participation.

Even though no one objects to the involvement of the doctors, there is an issue that needs to be addressed here. The involvement of doctors at this level does not only make it possible, but raises the probability of the prisoner being executed. When the doctor says that a prisoner is fit to stand trial, it means that the prisoner is subject to be executed should he be found guilty. If doctors are for the well being of their patients, they should not be deciding on whether somebody is fit to be punished or not, which they are in effect doing when they pass the prisoner to be fit to plead and stand trial. The doctor does not have a patient-physician relationship with a suspect when he determines fitness. But all the same, the doctrine of nonmaleficence does not only govern his relationship with his patient, but also with others. It demands that a doctor should do no harm.[107] By witnessing the doctor is not doing harm, but he is not doing anything to stop the harm that might befall the prisoner if he gets convicted.

There are two aspects to this issue. Firstly, it does not follow that when the doctor determines the fitness to plead and stand trial the suspect will be harmed. This is because the doctor might find that the suspect is actually unfit to stand trial. This, however, is not the important part. The main issue is that even if the suspect is judged to be fit to plead and stand trial, he will be harmed if in the end he gets executed, and the

[107] Beauchamp & Childress, 1989:120ff) say that nonmaleficence has three important elements. The doctor ought: not to inflict evil or harm, to prevent evil or harm, to remove evil or harm. The fourth one is not obligatory, namely that the doctor ought to do good.

doctor will have contributed to the harm. My argument is that the harm done by the doctor is justifiable. This is because it is morally better to harm the suspect this way than the harm that would result if the prisoner were not harmed. This is because the trial process' benefits far outweigh the harm that might befall the suspect. Not only that, the justice system depends on good and efficient processes so as to protect the larger majority of people.

We have to remember why sanity and physical fitness have to be established. Insane people are not accountable for their actions. Punishing them is immoral by utilitarian standards. We have to remember that Mill recognises principles of morality such as fairness, justice and retribution. Justice and fairness would demand that for any person to be punished, he or she must have behaved in a way that is not consistent with the happiness and interest of other people, and the person must have understood this when he or she committed the offence. He or she must have willingly and freely done something that is against other people's happiness. Punishment in Mill's view is the infliction of evil because an evil has been done and to stop further evil being done. In the case of an insane person the infliction of evil is pointless when he is punished. That does not promote happiness. Let us look at it this way. When an insane person does what is not in the interest of other people, an evil would have been done. If we punish him, we inflict another evil. But then we have missed the second component of the purpose of punishment—deterrence. This is because neither the insane offender nor other would-be insane offenders can be deterred by the punishment since they would not understand the purpose of the infliction of harm on them. Sane people would be struck with the fear that evil could be visited upon them for the things they do not understand. This would not promote happiness and therefore should not be done. Even capital punishment countries seem to accept that insane people should not be punished.[108]

If punishing insane and sick people is wrong, at least not to any advantage, it is better not to do it. If doctors are the only ones who can determine the health of suspects, then it is beneficial for both the suspect and the society for the doctor to determine sanity. Suspects benefit from medical involvement because when they are insane the doctors are able to say so. If doctors refused to render the service only they can provide, either insane people would be executed or the courts would be stuck without knowing what to do with probably insane suspects. This could lead to criminals thinking that they could get away with their crimes if they could manage to plant a seed of doubt on the courts about their sanity and therefore they would not be deterred from committing crime.[109] If this happened society would be more at risk. Criminals could get public sympathy if they were locked up without trial for the fear of executing them following faulty trials because of lack of medical expertise. In short, it will be more beneficial for doctors to participate than otherwise.

Mill, as stated above, holds that it is expedient for society to behave morally and justly. The injustice of punishing insane people could threaten the existence of society.

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[108] See for example, Hood (1996:92ff).

[109] In some cases it happens that the suspect's sanity becomes an issue, and they can get away with it if it happens to be doubtful. The point is that if sanity is important in determining a just sentence, it would be disturbing to execute somebody who showed signs of insanity. To lock them up in the absence of medically competent opinion or determination would be unjust because then their detention would be indefinite. A system that could not take care of society's insane members would probably produce undesirable results.

The principle that only accountable people should be punished, and that this should be done impartially, would not be upheld if doctors could not help with establishing sanity.

MEDICAL PARTICIPATION IN A CAPITAL TRIAL

Doctors should be involved in capital trials for the reasons that follow. First, assuming that it is in the interest of humanity for justice to be done and that helping in the pursuit of justice is beneficial, it appears to be reasonable to assume that doctors should be involved in the pursuit of justice unless such involvement bears disutility.[110] Justice is supposed to be attained by means of a trial in many modern societies. In the trial it is important for the judge and jury to get as complete a picture of what happened as possible. That enables them to make a fair judgement based on the belief that if anybody should be punished at all for something, it must be one responsible for the committed crime. If the suspect is responsible, the doctor's contribution may suggest how and why he is responsible and to what extent. This gives the justice system a certain amount of respectability and people can trust it (the system) as it appears to utilise objective means to arrive at a decision. So whilst testifying at a particular trial may result in the death of a certain prisoner on the one hand, it may be beneficial on balance. For example, one of the good benefits is that the jury and judge are helped to make a judgement that should not result in either the freeing of guilty people (which would have bad consequences) or executing innocent individuals (which could have bad consequences as well).

Some people feel that doctors should not be involved in giving evidence in capital trials because "here we find the anomaly of a physician, sworn to devote himself to the preservation of human life, dealing out opinions whereby the survival or destruction of another human being hinges on the turn of a word" (The British Medical Association, 1992:104-105). The objection seems to be running like this. The evidence of a doctor in a capital trial can be so crucial that the prisoner's conviction or discharge depends on it. If it does, the doctor contributes in a substantial way to either the freedom or conviction of the prisoner. Conviction leads to execution. So when the prisoner gets executed, the doctor has contributed in a substantial way to the execution. That is against his vocation of saving human lives. So it must be unethical for the doctor to be involved in a capital trial.

The above objection seems to have been answered by the British Medical Association who tried to make a morally significant distinction between giving medical evidence in a capital trial and medical determination of a prisoner's fitness for execution. They found that in a capital trial giving evidence for the elucidation of guilt or innocence appears to be a role that is accepted by the judiciary, the public and the medical profession. But they had moral problems regarding the determination by doctors of whether the prisoner lived or died—at the determination of the prisoner's fitness for execution. Doctors usually take life and death decisions and it is in cases where these decisions are inevitable. In the case of capital trials, there is no equivalent

[110] The attainment of justice might be assumed to be a deontological ground for execution, but what I am suggesting here is that the overall consideration is based on utilitarian grounds—it is not only morally right that justice be done, but justice should be done because it is the most beneficial thing in the long run, or overall.

pressure to make such decisions as it is up to the state to execute the prisoner. The doctor is called upon to contribute to the process of determining which choice to make, and this is morally troubling (The British Medical Association, 1992:107).

I reject the British Medical Association's position because it does not show that in the case of a doctor participating in a capital trial, he does not contribute to the subsequent execution of the prisoner. Or at least that he does not participate in the process that ultimately does. I think the doctor contributes to the death of the prisoner, and that contribution is justifiable. The reasoning that there is a distance between trial and execution could be useful for the consciences of the doctors. It is reassuring to them to think that they can contribute to justice by giving evidence at a capital trial while at the same time escaping moral responsibility or blame for the death of the prisoner at execution. But this does not work, as I am about to show. Consider an example. Judge tells me that he wants to find out whether Suspect is guilty. If Suspect is guilty, Judge will order him killed provided in addition to that Suspect is fit. I am the only one who can make this determination for Judge. I determine guilt. If guilty then Suspect is executed. I can claim that I am not responsible for fitness-determination, which once established means death for Suspect. But my determination of guilt, given fitness, leads to execution. There might be a separation between guilt and fitness determination, but the consequences are the death of Suspect or at least almost always when I determine guilt. There are two options before me when presented with Judge's request. Either I determine guilt or I do not. If I do not, there is no way I can be held responsible for the execution of Suspect, and given the importance of my position, there would be no execution if it is supposed to depend on guilt. If I however determine guilt, there are two options. I determine guilt and then fitness-determination, then execution. Or I determine guilt, fitness is determined, then no execution. The last part does not depend on me. So if there is no execution it does not mean I have stopped it. If I had hoped for this result, it would be a matter of luck or the good will of those to make the decision. The issue then is why I should take the risk of having Suspect executed by hoping that once I have determined guilt he could still survive execution. It seems to be better not to take the risk. For this reason the medical associations should be arguing that doctors should not be involved in capital trials that might lead to execution because there is more risk of execution from them doing so than if they do not. This is especially so when the doctor has to give the incriminating evidence or aggravating factors at the sentencing stage. This shows that the medical associations' position is untenable.

When a doctor gives true but incriminating evidence in a capital case he is right to do so. This is not because the execution is some distance away from the trial, and therefore he would not be responsible for the execution of the prisoner. It is because it is morally right for only the guilty to be punished, and giving incriminating evidence promotes this. One may reasonably argue that whilst giving evidence may result in the execution of the prisoner (bad consequences), it also yields more beneficial consequences, namely, objectivity, justice, trust and confidence in the justice system and deterrence of crime. The justice system would not work well without these. For law-abiding citizens, it is important that there be fairness. That is, they have to know that they will not be punished when they have not committed a crime and this is done fairly in a court of law where all the evidence has to be presented. Or when there is reason other than malice to explain certain behaviour, the system tries to discover that

and act accordingly, medical testimony being part of it.

The fact that the doctor may help the system to distinguish between those who have committed offences for various reasons and those who have not means that the criminally inclined citizens might not take chances in committing crime. The criminal can take his chances knowing that he will probably not be punished for his crime. Or at least he stands as good a chance to be punished for the crime as anybody else does. If the involvement of doctors in capital trials helps deter such citizens it shows that whilst it may be undesirable to have the criminal executed, it may be worse to have the innocent terrorised by criminals.

Further, truth seeking is important in criminal justice. If the doctor, for example the forensic specialist, is the only one who can provide certain information vital for the attainment of that goal, it appears to be more beneficial to have a policy that expects such a specialist to participate than one that does not. Non-participation by specialists in capital trials would seem to deprive the justice system an instrument with which to help make the system work. That cannot be for the greatest happiness of the greatest number of people.

Finally, if trials yield justice, it seems to be beneficial on the whole to have all people who can help the system of criminal trials to do so without exception. The pensioner, priest, actor, and doctor are all citizens who have the duty (if any has) to help the justice system in the same way. This is justified by the fact that the institutions of justice have special utility. An individual can be self sufficient in many respects. But one of the basic needs every individual has is that others should not hurt him or her (Mill, 1991:190). It is a moral right that every citizen can claim from society. The latter tries to safe guard the moral right by the institutions of justice. People would be hurt if justice were not preserved. Trials are means of trying to address that need.

PREDICTION OF FUTURE DANGEROUSNESS TO SOCIETY

A Working Party set up by the British Medical Association advanced the view that presenting evidence on future dangerousness of capital criminals is

> fraught with risks and the dangerousness element of death penalty legislation is a poor basis for making life and death decisions." Psychiatrists are called upon in these circumstances to say whether or not the prisoner will commit further homicide, yet all the evidence suggests that, despite their apparent certainty in individual cases, they are much more often wrong than correct (Hood, 1996:94-95).

Doctors should be involved in determining the future dangerousness of criminals because the society has the right to defend itself and to treat insane people kindly. This is in the interest of society. Some criminals may benefit if the safety of sparing their lives is established since they can escape execution. The doctors' testimony also provides another chance for the prisoner to survive execution, which lawyers do not provide. It is important that competent medical practitioners make assessments of prisoners' dangerousness.

The argument that assessments are usually inaccurate does address the important issue. It seems to suggest that psychiatrists are incapable of predicting whether prisoners will ever be dangerous in future. And, indeed, it is a genuine concern that people

incompetent should be able to determine the death or life of a prisoner. One would agree that it is counter-productive to leave prisoners at the mercy of unreliable evidence. But this is different from saying that psychiatrists have a special duty not to let their knowledge make things worse for defendants in criminal trials.

As for whether doctors should predict dangerousness if they are capable of doing so, one may wish to emphasise the importance of their involvement. We have to start with noting what psychiatry is all about. "Psychiatry has become established as a medical speciality ... and psychiatrists ... have achieved the status of expert for the purpose of assisting the law perform its role" (Bluglas, 1990:61), and "Forensic Psychiatry is concerned with the assessment and treatment of mentally disordered offenders, the provision of psychiatric evidence to the criminal and civic courts and the application of the law to psychiatric practice" (Mason, 1995:391). We have to remember that criminals are dangerous to society including insane ones. The law is there to protect people including some criminals. In the case of a dangerous prisoner who has been sentenced to death, he is still a danger to other prisoners and prison staff. If it is known how dangerous he is, through the help of the psychiatrists, safety measures can be taken to ensure he does not harm anyone.

A dangerous prisoner can also face danger in prison because attacking other prisoners can result in them killing him in self-defence. The reason for him being dangerous might be a psychiatric condition that could be diagnosed by the specialists and right medical treatment given. If it is determined that he will not be a danger to society the prisoner can benefit by being treated differently from if he were dangerous. He could be saved from execution. One of the last chances of a prisoner escaping the death penalty is for him to make society believe that he is not dangerous. Without the help of psychiatrists, lawyers would not be able to convince the court that the prisoner poses no further danger. This even helps the utilitarian argument that if the prisoner is not dangerous to society and there will be no further benefit from executing him, he may be pardoned.

If doctors were not able to tell the courts whether certain prisoners were dangerous, society would be forced to treat all prisoners as dangerous and that would be morally worse than if less dangerous criminals were treated differently. This is because prisoners who could reform would be executed with dangerous ones for fear of risking their recidivism. We have to remember that execution is an evil, only that it is a necessary evil. It is morally better not to do the evil of executing prisoners who could reform. This means if there were a less severe punishment that could serve the same purpose of justice and deterrence as capital punishment, a utilitarian would say that it is morally worse to execute somebody rather than punish him less severely with the same results. A harmless prisoner can fall into that category.

If they can, doctors should help identify prisoners who will be dangerous. If prisoners are executed after doctors have shown that they are likely to re-offend, the prisoners' execution is not the sole responsibility of doctors but that of the government or society as a whole. In a way responsibility on the part of the doctors for the execution of the prisoners is inescapable. For doctors are members of the society and therefore share responsibility for what society does or omits to do. The doctor cannot be blamed for the situation that the prisoner finds himself in. The doctor's role seems to have more benefits than the risk of or even the death of the prisoner. This is because more

prisoners can be saved from execution when they are judged not to be dangerous.

EXECUTION COMPETENCE DETERMINATION AND RESTORATION

Another case of medical involvement in the process of capital punishment is when a doctor certifies that a prisoner is competent to be executed. Should the doctor certify competence? And if the prisoner is incompetent to be executed, should the doctor treat him to restore competence? I would answer yes to both questions and claim that it is better for the doctor to be involved rather than not to be. This is because a doctor helps cure or relief illness rather than kill the patient. In the case of psychiatric illness it is morally better that a prisoner's illness be relieved because it is only when he is fully rational that he has his full humanity and therefore can be held responsible for his actions including punishment if necessary. Opponents of execution competence determination and restoration by the medical profession accept that doctors can testify that prisoners are insane which would postpone execution. I argue that they should still be involved and say it if the prisoner is competent. I agree with Radelet who says that if doctors refuse to participate in competence determination because they are afraid of helping the process that execute the prisoner, those who support capital punishment will be involved. This will result in incompetent prisoners not being represented, as their lawyers would not have medical evidence to prove insanity. Competence evaluations help to ensure that incompetent prisoners are not executed. If the government executed incompetent prisoners people can protest on the basis of medical evidence that can only be available when doctors get involved.

When prisoners are on death row and they get ill, they are less likely to be executed than when they are healthy. The moral problem for the doctor is that as one whose profession is to save life, treating a sick death row inmate has the undesirable consequence of the prisoner being executed. On the other hand, if the doctor does not treat the prisoner it means the latter will be most probably saved from execution at least for the duration of his illness, but at the cost of suffering from disease. This raises the question, which I have discussed in chapter four, namely, whether the doctor's duties to save life and reduce suffering are normally overriding. It also raises the question of whether pain relief can override life saving.

To find out whether doctors should treat prisoners to restore competence let us start with psychiatry. Psychiatric treatment can be carried out for the purpose of relieving psychiatric symptoms rather than for killing the patient. So when doctors treat inmates they are not in violation of the Hippocratic Oath. The criticism is that such a view is insensitive to the legal consequences of the doctor's action, namely the execution of the prisoner. The American College of Physicians has gone on to say that the view is also a distortion of the Hippocratic commitment, which must not be indifferent to patients as persons. Such indifference is unethical, they said.

The American College of Physicians (1994:43) however thinks that there is an exception to this and therefore argues:

> On the other hand, one can imagine circumstances in which an ethic of commitment to patients as whole persons might lead a psychiatrist to consider the legal consequences of therapeutic success and nonetheless decide to treat. For example, a delusional prisoner's self-mutilating behavior or a severely disorganized psychotic inmate's inability to eat invites

> the judgment that the urgency of relieving agony or forestalling an immediate threat to life outweighs the prospect of execution. This possibility merits an exception to the proscription against treatment that might restore the condemned to competence. But this exception should be sharply limited, to cases of **extreme suffering** or **immediate danger**.

The American College of Physicians adds that such treatment is consistent with the agreed view that preservation of life should not always take priority over relief of suffering the example being that of withholding life-prolonging treatment.

If for example, it is unethical to be indifferent to the treatment of patients as persons, what does being persons mean? Treating death row inmates whose competence to be executed may be restored is consistent with the view that a fully-fledged person should be helped to be in a state in which they can take responsibility for their actions, and that includes punishing them if indeed they have to be punished. All the doctor does in this case is ensure both that disease does not interfere with this and that the prisoner does not suffer unduly whilst in the process of being legitimately punished. This does seem to yield better results than the alternative. The suffering of ill inmates increases the amount of human suffering on the whole, and that is morally wrong.

The suggestion by the American College of Physicians that the case of extreme prisoner suffering should be an exception does not seem to answer the question they want answered. They want to say that prisoners should not be treated if that treatment leads to execution. My argument is that even in the case of extreme prisoner suffering treatment may lead to execution. This is because in the case of extreme prisoner suffering treatment can have two results. The first is that the prisoner can get healed thereby paving the way for execution to be carried out. The doctor would have treated the prisoner in spite of the impending execution. The American College of Physicians implies that this is better when it recommends treatment and I agree.

The second outcome of the treatment depends on the prisoner's illness. If the extreme suffering is caused by fear of death, the doctor can alleviate pain only to have the patient lapse back into the same condition again in a short time. In that case treatment would not necessarily lead to execution if conditions were such that there was no enough time between him being cured and a relapse into the same condition. In this case treating the prisoner would not have been done in the first place, because execution was not going to be carried out. It would have been done for a reason that is separate from execution—helping the prisoner. The case of treating prisoners who are suffering extremely does not therefore show that possible execution should stop doctors treating prisoners.

I think it is better that a death row prisoner be treated and freed from disease even if it means subsequent execution. Short but good quality life can be better than a long and painful one. So if a doctor cannot stop the execution of a prisoner then he should treat him all the same when he is in pain, in spite of the impending execution. This is because the prisoner will be better off awaiting execution in a healthy state than enduring suffering which can go on for the rest of his life in jail when the government waits for his fitness.

There are two options for the government if doctors boycott death row. The government may go ahead with the execution anyway in spite of the fact that the prisoner might be sick either mentally or physically and therefore incompetent to be executed. If executing the incompetent prisoner is an evil, then it appears doctors would improve the situation by ensuring prisoners are competent before they are executed. On

the other hand, if the government is worried about executing incompetent prisoners, they may decide to keep them in custody until such time that they can be competent. This is tantamount to keeping the prisoner in an unacceptable condition of sickness. The fact that prisoners could be kept in prison sick makes it imperative that doctors treat them. Otherwise doctors would be guilty of failure to help patients when they could do so.

Those who object to doctors' involvement in execution competency determination or restoration would still like them to show that certain prisoners are proved to be unfit for execution on medical grounds. I suggest that if doctors are able to tell this truth—that certain prisoners are medically unfit for execution, they should be able to tell the other side of the story as well—that the prisoner is medically fit for execution. It could still be better to have a world where prisoners are executed only when they are competent to be executed rather than when they are not. Executing ill prisoners may result in more public sympathy for the prisoner, and rightly so. This is because if capital punishment is morally right, it has to be done in the right way without violating people's moral rights. In the case of the death row prisoner the principle of desert demands that he be punished proportionately to his crime. The death sentence is the appropriate crime. So when he gets the sentence he deserves, he does not forfeit his right as a human being to be given medical treatment if he needs it. The prisoner's suffering should not be allowed because it is not part of his punishment.

There is some credit in the argument that doctors qua doctors cannot certify that a prisoner is fit for execution. This is simply because there is no medical condition known as 'execution fitness' or anything to that effect. So if and when a doctor purports to certify that a prisoner is fit for execution they have gone beyond their medical expertise. That may be a judicial or moral decision. It cannot be a medical one. What a doctor qua doctor does concerning a certain inmate is verify or falsify that the prisoner meets certain medical conditions. If these conditions happen to be what the judicial system considers to be acceptable for carrying out an execution they do, if the conditions are not suitable for an execution they do not. So the idea of doctors certifying medically that somebody is fit for execution is manifestly absurd if not a confusion of the medical role.

Radelet (1996:252) agrees that psychiatrists should participate in the determination of competence to be executed:

> when a severely psychotic death row inmate faces execution, what would happen if the most ethical and humane psychiatrists declined to help him on the grounds that they did not want to become involved? Only the meanest and most prosecution-prone psychiatrists would do the evaluations. Any boycott would be partial since there would be no way to enforce the ban. Indeed, it could be argued that ethical problems would arise for those physicians who *refuse* to assist defendants who need psychiatric testimony to convince a judge that they are incompetent for execution. At the same time, a physician who evaluates a prisoner and feels that the prisoner probably does meet the criteria for competence may be more ethically justified in telling the courts that he or she cannot render a firm opinion (i.e. one can never be absolutely certain of competence) than in testifying that the proof of competence is conclusive.

If a psychiatrist determines that a prisoner is incompetent to be executed and the government goes ahead and executes the prisoner, it is the government who bears the responsibility not the doctor. This opportunity would not be available if the doctor refused to participate. The determination that a prisoner is incompetent gives objectors

to capital punishment in general and those against the execution of the insane in particular, grounds founded on medical evidence to call the regime into question.

In the case of a finding that a prisoner is competent (legally though, not medically) to be executed, it is still more useful to make that determination than not to if capital punishment is morally acceptable or if it is going to take place anyway. Even if its morality need not be discussed as the medical associations hold, an individual doctor's conscience should direct them rather than a proscription. This is what the medical associations have done in other issues. The morality of abortion for example, is not settled and yet doctors still help with abortions for social reasons, up to nine months pregnancy without the same kind of proscription as found in capital punishment.

The doctor could refuse to give an opinion as (suggested by Radelet) to the competency of the prisoner, but give an opinion if the prisoner is incompetent. But then this is limited by the fact that the court could still order the doctor to give the necessary evidence. Otherwise if the doctor gave evidence and expressed no opinion as to whether a prisoner is competent or not, it would not be their responsibility if the government construed that as meaning competence and therefore went ahead with the execution. This would be reasonable because it would mean in competency examinations there would be two responses: no competence and no opinion, the latter meaning, "yes" or being subject to that interpretation.

TRANQUILLISATION

Should doctors tranquillise prisoners in preparation for execution? The main argument against is that doctors are for the protection and preservation of life not the taking of it. Asking them to prepare for death in this way is making them accomplices to the taking of life, which is against medical ethics. It could be argued as well that if the tranquillisation of prisoners makes them readier for execution and those carrying out the execution more comfortable in doing so, it normalises capital punishment thereby making what is intrinsically wrong (capital punishment) more morally palatable. I think that doctors should tranquillise prisoners as it is in keeping with their mission to save people from pain whenever possible. It is worse for prisoners if doctors refused to tranquillise them to prove that capital punishment is wrong because they will suffer. It is also better for execution staff to execute a tranquil person than one who is crying and fighting.

If we take a chaplain for example, we find that he gives religious support to the death row prisoner in such a way that the prisoner makes religious sense of what is happening to him and about his life. For example, the prisoner might be willing to go to his death and be docile and submissive before the prison officers as they tell the prisoner what to do in the process of executing him with the belief that nobody can kill him 'spiritually.' If that happened, we would not accuse the priest of being an accomplice in the prisoner's execution. It is however true to say that, for all we know, the prisoner was going to face his death more anxiously probably with bitterness if there was no spiritual counselling provided by the priest. As for the doctor's provision of a tranquillisation, we may see an analogy with the chaplain. If the prisoner is not

tranquillised he will suffer more. [111]

In the preceding section I quoted the American College of Physicians who said that the extreme suffering of the prisoner justifies medical involvement in treating him. I have shown that the position implies that treatment is better than non-treatment and the basis of such treatment is the pursuit of the medical goal of medicine to alleviate pain and suffering when they cannot save life. The case of anxiety and emotional suffering that the prisoner can experience when faced with execution should be treated the same way. Since doctors cannot stop the execution it does not mean the prisoner will not suffer and alleviation of suffering is one of their duties. It is not only good for the prisoner that he is helped, but it is a medical duty. So a society in which duties are carried out and pain is reduced is better than where they are not.

If capital punishment is morally wrong it does not give doctors the right to neglect their duty of alleviating pain. The morality of capital punishment does not determine the suffering of the prisoner. If doctors have a duty to alleviate pain, it does not cease because doctors are unhappy about the fact that capital punishment is immoral and they do not want to participate. It is morally worse if doctors refuse to tranquillise prisoners than if they do, because as I said above, doing their duty and helping alleviate pain create a better world. So the idea that tranquillisation "normalises" capital punishment should not be used to stop doctors carrying out their duty of alleviating pain. This is because there are other methods to make the point that capital punishment is morally wrong if it is, without allowing prisoners to suffer when they get executed.

It is also evident that execution staff can be psychologically affected by the reaction of a prisoner to his execution. Even if capital punishment is not morally acceptable, it does not mean the execution staff has no right to live their lives free from psychological problems and job-related stress.

SUBJUGATION BY MEDICAL MEANS OF AN INMATE FOR EXECUTION

I think doctors should give medicines that help in the subjugation of a prisoner before execution. However Mill says "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant" (Mill, 1991:14). This might be construed to mean that in the case of subduing a death row inmate, medical intervention for his own good would not be acceptable on its own. The minimisation of suffering is not just for the good of the prisoner, but for the good of those who are to execute him as well. This is consistent with Mill's utilitarianism. I also argue that the state has the right to be helped in carrying out its duties of justice and doctors should help.

Doctors may "use pharmaceutical or other clinical methods to subdue an inmate who

[111] Trombley (1993:46-47) records the following exchange: "looking at the ceiling while stretched out on a gurney waiting for a lethal injection is painful emotionally. ... the bottom line is, if you're going to be executed in an hour, or ten minutes you know you are going to be executed. ... I would think most people would be sick. I think I would be sick to my stomach. I don't know about you, but I think if I was waiting to be executed, I'd want an Alka-Seltzer' He raised his hand in despair and bellowed. '*So give the guy an Alka-Seltzer*! But they don't.' He thought again. 'I'd probably want a shot of something. But they don't do that. You're not supposed to have alcohol in the prison, so they can't give it to the guy."

is resisting execution. If sedation is provided in the absence of the inmate's request and consent, the physician becomes a participant in the execution" (The American College of Physicians et. al., 1994:36). According to the medical associations this kind of participation should be viewed as unacceptable for the doctor. I accept that doctors are participants in the execution process when they subjugate a prisoner in preparation for execution. However, I do not accept the suggestion that it is unethical. Just as they may make a forceful arrest, detention and a compulsory fine, the authorities may enforce the carrying out of an execution. When they do, the prisoner may suffer as a result, and the doctor's aid may be needed to minimise the suffering. There are two issues here. The state's right to carry out the execution and to oblige doctors to help on the one hand and the prisoner's suffering on the other. I have already showed the primacy of the legal institutions over medical ones and how this is beneficial. Now I will address the prisoner's suffering.

If we take Mill's statement above we find that it allows the subjugation of the prisoner. When the prisoner is subjugated, there is less risk of him injuring execution staff members. Subjugation would therefore be for the protection of those handling the prisoner. This is in his interest as well because if he endangers those executing him, it is likely that he might be hurt. So it is in his interest that he does not fight the staff and medical subjugation can help him in that regard. Either forcefully subduing the inmate or not executing him can solve the case of a prisoner who resists execution. If execution is to take place at all, the better option is the use of pharmaceutical methods than brute force. The following case demonstrates what could happen when a prisoner resists execution and force has to be used:[112]

> TEKOETSILE Tsiane, one of the five men who were hanged last Saturday was beaten with batons and shot with rubber bullets by prison warders hours before he was taken to the gallows.
>
> Fighting back tears, Okgabile Sekate, Tsiane's elder sister told **The Gazette** that "When we saw Teko 12 hours before he was hanged… His clothes and face were covered in blood and his ears were bleeding. His head and hands were wrapped in bandages. He had bullet wounds on his hip and belly and the bone on his elbow was protruding through the flesh."
>
> She says Tekoetsile mumbled that "as you can see they have already killed me. The hangman will only take a corpse to the gallows" (The Botswana Gazette, 1995:2-3).

The cruelty was allegedly the responsibility of the prison officials. Mr Bernard Lekoko, the then Commissioner of Prisons, is reported to have said that his officers beat up the prisoner to protect themselves. In this case since the inmate was fighting his executioners, they would have been justified to tranquillise him before the execution instead of beating him up.

The question is whether they would be justified to force him if he refused to take the tranquilliser. This issue is related to treatment to restore competence against the prisoner's wish. I discuss this here because the two deal with consent. What happens when prisoners refuse treatment that may restore them to competence for execution?

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[112] People who knew the prisoner referred to in the case told me that he used to be a soldier and he was very good in martial arts. He had attained the level of Black Belt in Karate. He could easily overpower a few of the prison guards. It is alleged that the prison guards feared him as he was strong and could easily hurt them even when he was hand and leg-cuffed.

The American Medical Association thinks that if doctors are to be involved in treating prisoners to restore competence they should get the latter's consent;[113] otherwise their action would be unethical. There are two problems related to this position. The first is that if the prisoners were not competent to be executed they most probably would not be competent to give consent for his treatment if incompetence results from a psychiatric condition. Who then should give the consent? The state as the custodian of justice should and usually does. This happens in other cases, when insane persons commit non-capital crimes the state enforces their treatment even if their relatives and other people do not consent. Then doctors should be able to help the state.

There is a psychological impact on the execution staff resulting from forcefully subduing prisoners before executions. If the medical people do not help the execution staff the latter would not have pleasure in forcefully subduing the prisoner. They may have psychological problems as a result. If however the execution staff enjoyed forcefully subduing an inmate for execution it would be bad because they might have their sensibilities to the suffering of others numbed and that is not good for society. So the prisoner's subjugation by medical means would not only be good for him but for those involved in the execution as well.

LETHAL INJECTION AND RELATED PREPARATIONS

The selection of injection sites, inspection and testing, consultation with and supervision of those who inject the lethal agents, monitoring vital signs during executions, and professional observation of executions are most probably what doctors can do better than anyone else. If there were professionals other than doctors who were able to do these things to the same professional level as doctors, doctors would not have to be involved. The medicalisation of capital punishment means that either medical professionals carry out these tasks or they train people who will do as long as capital punishment is carried out and in a humane manner. Putting the morality of capital punishment aside, as the medical association would want to do; the issue is whether if capital punishment is continued, it is better to medicalise the practice. I maintain that it is better to medicalise it than not to. The reasons are that the prisoners do not suffer as much as they would without medicalisation. It is better for those who have to administer the punishment since they can do their work with less of the moral trauma that could be associated with executing someone without the help of medical professionals.

A botched execution causes mental trauma. For example "Tefaro's execution was the third that staff writer Bruce Ritchie had covered for the *Florida Times-Union*. He wrote, 'I don't know if I want to watch another.'" This is because "Jessie Tefaro's execution was probably the most gruesome in U.S. history. It led to a move to stop executions in Florida" (Trombley, 1993:49). Tefaro is reported to have remained alive for about seven minutes after the beginning of his execution. It took three attempts to

[113] Doubt has been cast as to whether incarcerated death row prisoners can give valid consent to donate their organs. (see for example, Radelet, 1996:247). If that is the case, it could well be that prisoners might not be able to consent to their treatment for competence to be executed. The point is that if doctors could be allowed to harvest organs from consenting death row inmates, they should be allowed to treat consenting death row prisoners for competence to be executed for the same reason. If doctors are allowed to treat consenting death row prisoners for execution competence, they should be allowed to harvest organs from consenting death row inmates. I will return to the organ donation issue below.

electrocute him before he was dead. He appeared to have suffered more than the executioners had expected. The sight of smoke horrified the observers of the execution and the executioners, and some sparks or flames on the cloth that covered the prisoner's head. It appeared as if the prisoner was burnt alive.

The case of Tafero shows how the prisoner can suffer with the non-involvement of the medical professionals. It also shows how non-medicalisation might not enable the medical determination of the prisoner's pain and suffering. This is because the doctors who were involved in the case are able to give well-considered medical opinions that could help in the understanding of capital punishment as carried out under those conditions. The important thing is that doctors know what signs to look for in order to determine pain and so on. For example:

> Dr Kirzschner believed that 'Mr Tafero did not receive the prescribed lethal dose of two thousand (2000) volts of electricity that was reportedly applied,' and that 'the failure to administer the requisite voltage combined with the other physiological reactions noted by observers of the execution raises the substantial possibility that Mr Tafero experienced conscious pain and suffering during the execution.' He criticized Secretary Dugger's letter to Governor Martinez, in which Dugger claimed 'the autopsy report and attending physician's account reflect instant death.' Kirschner wrote, 'I find no such statement in either the autopsy report or the affidavit of the attending physician, Dr Kilgo. The autopsy cannot possibly determine how rapidly unconsciousness or death occurred in this case' (Trombley, 1993:68).

Intramuscular and intravenous are the two kinds of lethal injections used in executions. All this insight would not be available if doctors refused to be involved in capital punishment. A crude knowledge of intramuscular injection for example could result in a painful execution for the prisoner. Intravenous injection may not be suitable for all prisoners.

> For lethal injection purposes, an intravenous injection is necessary to ensure unconsciousness, followed by death, in short space of time. Intramuscular injections would be undesirable because they are **extremely painful,** and because the lethal drugs would take **minutes** rather than **seconds** to take effect (emphases mine). Doctors explained that giving an intravenous injection is a skilled procedure, and one that requires constant practice to maintain. Successful intravenous injections require the full cooperation of the subject, which cannot always be guaranteed during an execution. And, a percentage of the population suffers from venous abnormalities which make it extremely difficult to administer an intravenous injection. (in the case of American prison inmates today, a significant proportion of whom are former drug users, the administration of an intravenous injection is frequently difficult.) Then there was the problem of which drugs to use, and what would constitute a lethal dose (Trombley, 1993:82).

There is also the question of the administration of drugs about which doctors have expert knowledge. Refusal by doctors to help to administer drugs might mean the employment of crude methods that could end up hurting the prisoners more than necessary, and taking an emotional toll on the executioners. This is demonstrable by the example of Jack Pursley who without medical knowledge, attempted to execute a prisoner by lethal injection. Pursley was a warden responsible for executions in a Texas prison. Medical doctors were not allowed to train him. The first time he attempted to execute a prisoner, the doctors who attended the execution could not help him as they were prohibited to do so:

> he took all the chemicals and mixed them together and put them in one syringe. The doctor stood there watching him. Some forty minutes later, after they got everything set up, they go

> in there and he's pushing the syringe and the syringe won't work. He's got *white sludge. Everything precipitated*. You can't mix the three chemicals together.' The doctor stood there shaking his head and said, "I could have told you that." Fred exploded with exasperation. 'You know, give him a break! You've got a man who doesn't know anything about medical procedures, and here he's doing something—he's totally out of his element—and the doctor is going to allow him to torture the inmate! (Trombley, 1993:85-86).

The prisoners' suffering as a result of non-medicalisation of capital punishment, particularly the non-involvement of doctors in lethal injections raises a moral problem for a utilitarian. This is because since capital punishment is meted out to murderers on the basis of desert and its utility, it is unjust to impose unnecessary suffering on the prisoners. It is also unjust to cause pain to the executioners who are not medically experienced to deal with executions.

ORGAN DONATION

The involvement of doctors in capital punishment may give opportunities for the harvesting of executed prisoners' organs for donation to needy patients. This gives rise to the question of whether it is morally appropriate for doctors to be involved in transplanting those organs from prisoners, when the prisoners consent and when they do not consent. I maintain that doctors should be involved in harvesting organs from prisoners who have been executed because that will save and improve many people's lives. When prisoners refuse to donate their organs there is still a justification to harvest the organs, which is that they have forfeited their right to consent, a justification that seems to be at work in punishment generally and capital punishment in particular. This can also be justified on the basis of justice.

The issue of consent is taken to be important—so much so that if a prisoner could be shown to have given informed and free consent for the use of his organs there would be no objection from many quarters, let alone from the medical associations (Radelet, 1996:244-245). Indeed, consent is held to be important in many areas such as sexual relations, medical treatment, governance (democracy) and so on. It derives from the belief that a world in which there is freedom is better than one where there is none. Consent is an element of the exercise of freedom. Mill also recognises this and says, "over himself, over his own body and mind, the individual is sovereign" (Mill, 1991:14).

I maintain that a prisoner's organs may be harvested without his consent, and that can be done on utilitarian grounds. If we assume that the prisoner consents to his execution because he consents to the judicial process and other benefits of being a member of the human society, it would be consistent to say that he consents to the use of his organs even if he does not like it. This is because in capital punishment we see an example of moral rights being waived or forfeited. Society has come to this position because of just punishments and their usefulness—people deserve to be punished according to the gravity of their crimes. One can easily imagine a case of a murderer deserving more than just a death sentence—mass murder. In this case the murderer cannot pay for the lives of all the people he has killed since he has only one life to give. Something approximating to what he deserves would be to not only execute him but also get more—his organs. Here the moral justification is that of justice, which is

expedient to uphold.

Some people might object to the involvement of doctors in prisoners' organ donation because of their opposition to capital punishment itself. Their argument is that capital punishment is morally wrong. If some good resulted from it, that is, the donation of organs to patients who would otherwise die or whose lives would be improved by the organs, it would result in the acceptance of capital punishment itself, and that would not be good. Even from a utilitarian point of view, there would be some disutility. For example, the prospects of organ harvests from condemned prisoners would make jurors and judges return the death penalty more readily than otherwise. This would result in undesirable consequences because the service of justice would become secondary to the saving of patients who could benefit. The objection to capital punishment itself is not going to be resolved now. But the objection itself concedes to utilitarianism—that capital punishment is beneficial. So one need not go any further than to say that it is also deserved in the case of murder. As for the jurors and judges returning the death sentence simply because of its benefits, they would be acting unjustly, and therefore they would need to be trained in being impartial and fair, values that are espoused by utilitarianism.

It seems to be clearly indisputable that if prisoners for example could donate their heart, lungs, kidneys, liver, blood and so on, more patients would be helped. That is good in itself. The unpleasantness caused when the prisoner does not consent to donate his organs after being executed might very much be outweighed by the benefits. Generally capital punishment is wasteful as currently practised in many countries.[114] The issue of prisoner organ donation is a step toward addressing that waste. It seems absurd to argue that it is better for a human body to be eaten by worms or the furnace of cremation than to use parts of it to save or improve some human lives if we hold that it is morally better to save human lives.

It could be that a lot of people might be upset by the suggestion that prisoners donate their organs. Even if they were, it seems to be better to inform and show them why they should not be upset. In any case, if capital punishment is acceptable it does not seem to be rational to think that using a dead person's body parts is worse than executing him.

If society is educated to understand that executions are carried out following a morally authoritative process of law—juries and judges trained to be fair and impartial in their judgements of capital trials, and that the authority of such processes is based on principles of justice, society would not be hurt by the harvest of organs without the prisoners' consent. It is not clear that the prisoner would be hurt either supposing people can only be hurt when they are alive. Doctors should participate in this process.

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[114] The question may be asked as to whether this implies that death among non-executed people is wasteful or not. Even though this is not directly relevant to my topic, it does seem to be the implication. People may feel that they should be buried with their bodies (or their relatives') intact but that is more wasteful than if the organs could be used for needy patients. This is what the British Medical Association has realised and are therefore agitating for legislation to enable their members to assume consent to donate organs on the death of patients instead of the current practice where consent has to be sought.

CERTIFICATION OF DEATH

Certification of the death of an executed prisoner by doctors does not seem to raise objections from any one. The medical professionals think it is all right, if the certification is done away from the place of execution once somebody else has determined death. It is interesting to ask why it is important that doctors should be asked to certify the death of an executed prisoner and why they do not see that as problematic. What is important is that when the doctors certify the prisoner's death, they are carrying out their civic duties while at the same time serving justice. The state, in carrying out a just sentence of death, must ensure that the executed person does actually die and not suffer the pain and indignity of being left half-dead following an attempted execution. This should be ensured even if capital punishment is not justified. The certification of death by doctors is necessary, as they are the only ones technically qualified to do so.

CHAPTER 8

THE MEDICAL DOCTOR AND A CONDEMNED PRISONER

In this chapter I am going to look at the medical doctor's social responsibilities, the position of a condemned prisoner in society and how the two are related. Does a condemned prisoner have a physician-patient relationship with the doctor? Does that determine what the doctor can and cannot do for the prisoner? It is quite clear that in some cases the two can have a doctor-patient relationship, in which case they may relate in a way that is suitable for that relationship. At other times they might not be related in that way, in which case it would be clear they could not be related as if they were doctor-patient. There are some unique situations that are not clearly definable as either being doctor-patient or not doctor-patient relationship. I am suggesting that the condemned prisoner is in that position. It is therefore necessary to be open-minded about the involvement of the medical doctor with the death row prisoner. This is because there are many moral issues involved. I will first of all look at the social position of the doctor and suggest that it has not been univocally understood throughout the ages. The role of the doctor in society has and will still change. I will then argue that this change should include the involvement with condemned prisoners as long as capital punishment is used and acceptable as a form of punishment. What is of paramount importance is that the medical doctor's role in society is not restricted to the treatment of patients. Restriction of the medical doctor's role only to doctor-patient relationship can lead to immoral consequences. I also suggest that the medical doctor is not unique. An examination of ethical codes of a few professions suggests that they are basically concerned about the well being of society just like the doctor.

To do the above I would like us to look at a brief description of the history of the way medical doctors have been perceived. The question is does that give us a monolithic development? Has the doctor been understood in the same way throughout history? This is an important question since the main focus of those who object to the medical involvement in capital punishment are mainly grounded on the nature of medicine and its goals. Just a few pointers will show that this is not as simple as suggested.

THE SOCIAL POSITION OF THE MEDICAL DOCTOR IN HISTORY

Maybe the important question one would be expected to answer is whether or not medical doctors can be shown to have been involved in capital punishment throughout the history of the two institutions. Whilst it is an important question, it is very unlikely that it will yield the desired results. It is very probable that doctors were never involved

in capital punishment in the past. It could also be that doctors were never involved in capital punishment in the past because they never perceived capital punishment as a practice that required their presence not because it did not involve medical conditions but because the capital punishment environment did not lend itself to societies then as something necessitating the involvement of doctors. This will remain speculative until somebody carries out a research to settle the question. The question as to whether or not capital punishment involved medical doctors in the past, and if not why, and if it did, why, will therefore be put aside for now.

By the 'social position of the medical doctor' I want us to understand the way the medical doctors were perceived with regard to morality, including their own perceptions. I cannot be exhaustive at this point, but a pointer will serve our purpose. To begin with, in antiquity medicine was regarded as an art. By 'art' let us understand 'the technique and knowledge of doing something.' From that perspective the art of medicine would not be any different from any other art such as designing, drawing and dancing. However, what makes the art of restoring health or saving life (if that is what we may call medicine), is that it relates to something dear to human beings—their life. It raises ontological and religious feelings and questions. Questions such as 'is someone capable of developing an art that is for saving life the same as one who has the art of say, drawing?' Inevitably, the answer is negative. This is because human beings regard their lives as the most important thing. In fact, human beings have gone to the point of supposing their lives to be sacred, hence, the religious-ontological underpinnings.

From the aforesaid, it is probable that one can understand why the medical art would occupy such an important position in the society. In fact, medicine and the medicine persons become divine. In short, because human beings believe in the sacredness of their lives, they project that one who knows the art that deals with the sacred lives should have some kind of divinity. In other words, if stones, rocks and mountains were believed to be sacred then geologists and related scientists would acquire the status of divine specialists.

Amundsen (1978:24) has argued, "there is abundant evidence that, at least among the Greeks of the fifth century B.C. and later, health was considered both a virtue and an indicator of virtue." This is important in that it reflects the belief system of the time, which was largely religious. Virtue and religion were inseparable. By ascribing virtue to health, the Greeks were imputing some kind of divinity to health and health technicians/artisans—by pursuing health for others doctors were in actual fact pursuing virtue. By extension it was necessary that they themselves should be virtuous. This for me would seem to explain why medical doctors or the profession of medicine acquired the status of a divine calling. It was the belief about what health was and what the human being was that generated the status of the profession. Whether or not this belief was right is another question, but this is important for our purpose because we can then see why doctors today should be perceived in a different or similar fashion.

The ancient Roman and Greek societies did not have medical professions as we know them today. Anybody interested and willing could practice the art of healing (Amundsen, 1978:23). One would suppose, probably the artisans of health practiced rather like the African herbalist of yesteryears, who did not need licensing but got patients depending on their ability and fame amongst the people. Talking about the Greco-Roman doctor of antiquity, Amundsen (1978:23) supposes, "by the most basic

definition, he was one who practiced the art of preserving or restoring health. If the primary function of the classical physician was preserving or restoring health, ideally he should be a compassionate man." I think this supposition is most likely among those that have led to the divinisation of medicine. It is however expedient to point out that being an artist/artisan of health does not imply compassion. One might do it because it is fun and brings about a lot of power over human beings. Another might do it because they inherited the skill from their parent. So there is no good reason why there should be a linkage between practicing the art of health and being compassionate. The connection, as pointed out above, comes about because of the belief about human life and preserving it, which the Greeks considered to be one of the important virtues as Amundsen has pointed out.

Even Amundsen (1978:23) himself has pointed out that the apparent timeless ideals of medicine that are in consonant with the present day medical ethics have never been held by a majority of practitioners in the classical period. In fact, the motivation for practicing medicine was money, honour, glory and other things besides philanthropy. It could be that following the classical period up to the present times, medicine has re-evaluated itself and has come up with the right motivation for practicing medicine, which is philanthropy and concern for the well being of humanity that include compassion and love for the patient.

It is interesting however to observe that at least there are signs that virtue and compassion will not dominate the core of medical ethics as a motivation for practicing medicine for ever. Beauchamp and Childress (1989:381) have pointed out:

> Some virtues are correlated with professional obligations and ideals, as professional codes often indicate. Insisting that the medical profession's "prime objective" is to render service to humanity (reward or financial gain being a "subordinate consideration"), an AMA code in effect from 1957 to 1980 urged the physician to be "an upright man," "pure in character and …diligent and conscientious in caring for the sick." It also endorsed the virtues that Hippocrates commended: modesty, sobriety, patience, promptness, and piety. However, in contrast to its first code in 1847, the AMA over the years has deemphasized virtues. The references that remained in the 1957 version were perfunctory and marginal; and the 1980 version eliminated almost all traces of the virtues, except for the admonition to "expose those physicians deficient in character or competence."

One has to add that the code admonishes practitioners to provide "competent medical service with compassion and human dignity" (Callahan, 1988:451). This might lead one to think that a big part of the traditional attitude about the medical practitioner is still present in the code, which would rather weaken Beauchamp and Childress' above quoted point. However, article VI of the code states that the medical practitioner is free to choose whom to provide with medical care and attention unless there is an emergency (Callahan, 1988:451). This is instructive because virtue demands what is over and above the normal. It would therefore appear that if the code stuck to the traditional view of medicine as a profession for the virtuous, it would expect the medical professionals to practice their skill in the service of everybody as long as they are able to do so. In other words, virtue demands total, selfless and unflinching dedication to the well being of one's patient irrespective of what the individual doctor would otherwise prefer. The implication we can draw from this is that after all the medical professional is no divine being, but just as ordinary as the other professionals.

It is instructive in this regard to observe that the 1980 code sees a medical

professional who recognises a responsibility to contribute to the well being of society (article VII) as well as a responsibility not only to patients but also to society, other professionals and to the self (Callahan, 1988:451). This is consistent with the ethical code of the American Society for Public Administrations (Callahan, 1988:458), which states regarding ethical conduct:

> *Ethics* involves applying principles so that we might order our values in particular situations. When two or more values make conflicting claims on our conduct, ethical reflection helps us decide the paramount value in that particular context. Principles, such as those dealing with justice, freedom, honesty, beauty, order, and loyalty are employed to sort our values and establish priorities among them. These principles are derived from a variety of sources, including the family, schooling, religion, socio-cultural environments, and professional identities.

Engineers are also required to provide service to the society with honesty, impartiality, fairness and equity. They must also be dedicated to the protection of public health, safety and welfare. They must adhere to "the highest principles of ethical conduct on behalf of the public, clients, employers and the profession" (Callahan, 1988:460). Social workers are also urged to be ethical in their conduct. All these would seem to imply that medical professionals should not see themselves as being separate from society to the extent that when some apparently moral actions are acceptably carried out by some people in society, it would be immoral for the medical professionals to carry them out. In the context of capital punishment, if it is morally right for an executioner to execute a condemned criminal, it does not seem to be rationally justifiable to suppose that medical professionals would not do it simply because they are medical professionals. This is because as stated above in the AMA code, medical professionals have social responsibilities.

This is not of course to deny that the medical professional at least is presented with a tension between the demand to protect life and justifiable killing if that is what capital punishment is. But to show that the medical doctor is not and should not be viewed as occupying a peculiar position in terms of carrying out certain actions should be a pointer towards the fact that maybe doctors might be involved in capital punishment for some other reason in spite of the medical demand to save life. This is so especially if capital punishment is morally justifiable at least in cases of execution for murder. I will now turn to the relationship between a medical doctor and a condemned prisoner and ask if the latter is a patient or not.

THE MEDICAL DOCTOR IN RELATION TO THE CONDEMNED PRISONER

One important criticism that can be made of this book or the thesis I am advancing is that a condemned prisoner does not have a doctor-patient relationship with the doctor whom I think should execute him or her. In this section I want to show how and why the prisoner can be seen as a sort of patient for the doctor. I also have to point out that even if the condemned prisoner does not have a doctor-patient relationship with the doctor, the latter can still execute him on other morally acceptable grounds such as human compassion and social responsibility.

To begin this debate one has to establish what a patient is. A simple description of the word "patient" is to say that it is someone in need of medical assistance resulting from some form of suffering. Cassell (1982:640) says that he was unable to come to a

comprehensive and clear explanation of what suffering is. He only found that it was always associated with the word "pain".[115] We could still say that a patient is someone experiencing some form of pain. Pain and suffering have different forms ranging from psychological, physical, emotional and so on. Cassell however makes a distinction between pain and suffering. He suggests that the former may cause the latter. That is, people can have severe pain and suffer less in proportion to the pain. They could suffer more from little pain depending on the circumstances surrounding the pain and suffering. The important thing is that a patient can experience both.

The question of what a patient is does have relevance to what sickness is. This is also a difficult question. Cassell (1982:640) cautions:

> It is not possible to treat sickness as something that happens solely to the body without thereby risking damage to the person. An anachronistic division of the human condition into what is medical (having to do with the body) and what is nonmedical (the remainder) has given medicine too narrow a notion of its calling. Because of this division, physicians may, in concentrating on the cure of bodily disease, do things that cause the patient as a person to suffer.

Cassell (1982:640) goes on to point out that "suffering is ultimately a personal matter. Patients sometimes report suffering when one does not expect it, or do not report suffering when one does expect it."

The question then to ask is whether or not condemned prisoners are patients in the sense. From what I said above, it should be clear that prisoners are some kind of patients. Prisoners (those on death row) are patients because they suffer. Johnson (1998:95) has observed that prisoners' lives are

> monotonous and lonely, and they are predictably bored, tense, and depressed. Chronic irritability and periodic lapses in personal self control can leave prisoners feeling alienated from themselves. The prisoner comes to see himself as essentially a stranger in a strange land.[12] Powerlessness and its emotional sequelae, established in the *Harries* case as key factors in the cruelty of Tennessee's death row (see Chapter 3), affect prisoners on all death rows.

Life in death row is described as a kind of hell; there is loneliness, boredom and fear. Johnson (1998:104) describes the state of affairs:

> Many condemned prisoners describe death row as a human pressure cooker. Tension is pervasive, pernicious, and, in varying degrees, disabling. Symptoms of depression and lifelessness are common. […] "The main thing," said one condemned prisoner, "is the mental pressure: you're always depressed. But I think another main thing is the physical deterioration of the body. You sit up there and you just feel yourself getting weaker, you know? Your back hurts, ya know/ You're sick a lot—cold and low blood. You lose your energy."[46] […] "I'm already walking on a hairline of being sane and insane," observed one prisoner, "I could fall either way at any time."

The death row prisoner is described as being defeated, dehumanised and thoroughly subdued by the conditions in death row by the time they get to the execution stage (Johnson, 1998:143). One prison officer described the last hours of the death row prisoner and the way they felt as being like in a trance. One said of a prisoner "his mind goes first. …All resistance disappears, they're exhausted." Another one says, "a lot of

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[115] He searched the social science and medical literature. The data bases he used were *Psychological Abstracts, Citation Index* and *Index Medicus.*

'em die in their minds before they go to that chair" (Johnson, 1998:155).

If the above show death row prisoners to be patients, it does not necessarily mean the doctors should be involved in killing them. But if the prisoners have to be killed at all,[116] then it would appear the doctors should intervene to reduce pain and suffering, which is part of what medicine is for. One cannot overemphasise the fact that it is normally acceptable within medical circles that if the physician cannot heal the patient, the least they can do is alleviate pain. It is clear that medical doctors have not mounted the best of campaigns to do away with capital punishment. It might as well be the case that some of them believe in it. In one of the chapters above it is clear that doctors do not wish to discuss the morality of capital punishment. That means they are not in a position to influence capital punishment states towards abolition. What this means is that de facto medical doctors are not in a position to stop the human-made disease or disaster that is capital punishment. The only option open to the doctors then is to minimise evil by seeking ways to reduce the pain and suffering of prisoners.

It is also important to observe that usually medical doctors do not inquire into the cause of a disease before they treat the patient. For example, cancer patients who got the disease probably because of smoking are usually treated even if the doctors have warned the patient about their smoking habits. This is so especially when the patient is in immediate danger. This is done in spite of the moral responsibility that the patient has for the sickness. Likewise, we can say that the illness of death row prisoners is human made, but that in itself cannot be used to disqualify them from being treated by the medical professionals.

There is another reason for medical involvement with death row prisoners. It is quite clear that whilst the execution of a condemned prisoner is a legal process, it is not necessarily a moral one. This means whilst morally acceptable laws may be enforced the application of those laws does not necessarily mean moral responsibilities should not be shouldered. The prisoner's apparent loss of the right to life does not necessarily mean medical doctors should not attempt to reduce the amount of suffering associated with being executed. If medical doctors cannot assist the prisoners as a matter of duty arising from medical ethics, at least they should do it as an act of compassion and mercy. It would be like the doctor saying to the condemned prisoner, 'look, I am not the one executing you. But since they would execute you anyway even if I refuse to participate, my involvement is only in so far as to help alleviate your pain and suffering.' Of course, the doctor does not have to be involved if the prisoner is against it.

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[116] It appears there is support for capital punishment. In Botswana for example, there is a belief that many people support the punishment. In Russia "the majority of the populace is against the complete abolition of the death penalty. […] A significant portion of those who replied (69.1%) believed that the death penalty should be applied but only in the most extreme instances and as frequently as possible. These included: 61% of adolescents; 78.1% of young people; 66.4% of middle-aged people: and 70.2% of those over 60 years of age. By education this category of citizens was distributed as follows: 57.9% had no secondary education; 67.4% of those having a secondary education; and 74.8% of people with a higher education. Among workers, 63.9%; among teachers and scholars, 67.7%; among employees, 71.5%; and among students, 81.6%. The victims selected this variant less frequently (62.6%) than those who had not suffered from crimes (Mikhlin, 1999:170-171). This means in such territories it is not easy to abolish the punishment. There is not much that medical professionals can do if there is no political will to do away with the punishment.

CONCLUSION

Should medical doctors participate in the execution of convicted criminals? Is it morally right? There are two issues here, the morality of capital punishment, and the morality of medical doctors' involvement in the process. It could be that the morality of the medical doctors' involvement in capital punishment depends on the morality of capital punishment itself. The medical associations think that the two are separate, and the former does not depend on the latter. They reject what they have called the "medicalisation" of capital punishment on the grounds that it is against the goals of medicine. Amnesty International rejects capital punishment and think its medicalisation is morally worse because not only is capital punishment wrong, but the involvement of doctors by medicalisation is against the goals of medicine.

In this book I have been considering the morality of medical doctors' involvement in the wider process of capital punishment and what the medical associations call "medicalisation" of capital punishment, which means lethal injection and closely related stages. People who subscribe to what I called the "Separatist Thesis" oppose medicalisation on the basis of this thesis. I have rejected the thesis, which holds that professional morality, for example, medical ethics, is separate from and independent of ordinary morality. I have argued that there are general principles of morality that provide the foundation of all morality. Different professions are instances of the special application of these general principles. I have made use of Gewirth's view of morality to come to this conclusion. He argues that people have moral rights that are derived from what he calls the "Principle of Generic Consistency." This means every individual has a generic right to pursue her or his interest and well being without impediment as long as they do not impinge on others' right to their own interest and well being. This right is universal, and society has created institutions that protect these rights. Punishment is an instance of impinging upon someone's right on account of him or her having violated another's right.

I have not only rejected the Separatist Thesis but have gone on to suggest that in protecting the interests of everyone, society has created legal institutions and roles that are intimately connected with promoting justice. These roles may involve doctors. This means doctors have duties that go beyond medical ethics. The goals of medicine are morally justified only in so far as they satisfy the conditions of general morality. This means they have other duties besides life saving. For example, they may be morally justified to euthanise some of their patients who request them. At least they may let some of their patients die.

There are other activities in which doctors are involved that can result in death. The military is such an example, where the doctor works for an institution that may kill people in a war situation. This involvement is justified on the basis of general moral principles such as self-defence. Some medical involvement may necessarily be to the interest of the patient but are justified on other grounds. Examples are sports like boxing and medical involvement with senior political figures.

All of that said it might still be true that capital punishment itself is morally wrong,

and that is why doctors should not be involved. Amnesty International has advanced this position. But even if capital punishment is morally wrong, medical involvement may still be justifiable because it makes the process more humane than if doctors were not involved. In Appendix 1 I have given the example of the Nazi death camp prisoner-doctors who killed their fellow prisoners and helped in the selection of those to be killed. Normally it is morally wrong for doctors to kill their patients. In their case it was the lesser evil. In the same way, if capital punishment is morally wrong in comparable manner to the death camp, medical doctors should be involved in executions.

There are two philosophical theories that can be used to argue in favour of the medicalisation of capital punishment. Kant thinks that capital punishment of murderers should be carried out as a matter of duty. This should be done with dignity being maintained for the prisoner who is to be executed. Even though Kant did not address the issue of medicalisation, one can construe from his theory that medicalisation could be acceptable to him, even though some stages of the process might not. This is because lethal injection is the latest technique that is probably the most humane way of executing somebody. If capital punishment is morally right, lethal injection is the best method of carrying out the procedure without insulting the dignity of the prisoner. The state has a moral right to expect doctors to help it in carrying out its duty of justice. This raises a categorical imperative for doctors to participate.

Utilitarianism, at least in Mill's version, would allow medicalisation on the basis of justice and desert. If capital punishment is the execution of a just act by society, and the prisoner's pain is not part of the just sentence, the prisoner should not be allowed to suffer the pain; otherwise it would be an injustice. Injustice should not be perpetrated because it results in bad consequences. Doctors should be involved in the execution process because they are the ones who have expert knowledge especially in the case of lethal injection. They have a duty to protect society, and if their institution does anything that is in conflict with the institutions of justice, they would have to be done away with.

I have made a case to show that the positions that are against the medicalisation of capital punishment are at least weak. I have also shown that there are valid arguments that can be advanced in favour of the medicalisation of capital punishment especially in the case where it is practised and doctors and those against it are not in a position to stop it.

APPENDICES

APPENDIX 1

ANOTHER EXAMPLE OF JUSTIFIABLE MEDICAL KILLING: PRISONER DOCTORS IN THE NAZI CAMPS

We have seen above that the medical role is not independent of other roles. We also have seen that it does not only require the preservation of life. I have argued that the military doctor role is justifiable even though it may involve doctors in killing or helping to kill in a war situation. To show in a similar way that it may be morally right for doctors to be involved in capital punishment even if the penalty may be morally wrong, I would like to take the example of medical involvement in activities that are normally out of the question for doctors. These are the selection for execution, abortions and actual killing by medical doctors. The case of Auschwitz is a good example. In using the holocaust the aim is to argue that what the prisoner doctors are said to have done is difficult but morally justifiable by the principle of lesser evil. It is important to point out at this juncture that capital punishment might not be morally comparable to what happened at Auschwitz. So an attempt to make some comparison might be out of place. This is because, granted that some people think capital punishment is morally wrong and others think otherwise, many if not all would agree that Auschwitz was morally wrong. We may however benefit if for argument's sake we assume that capital punishment was as immoral as Auschwitz. So I will proceed on that basis. Thus, if capital punishment was so evil that it could be comparable to the Nazi death camps, would it be morally wrong or right for doctors to be involved in the medicalisation of capital punishment?

At Auschwitz some prisoners were doctors, and it became convenient for the Nazi security (SS) to enlist them into the project of killing, giving the rudimentary medical assistance required and experimenting on the Jewish prisoners. This was done with the connivance of German medical personnel some of whom were all too eager to participate. Lifton argues that the other reason Jewish prisoner doctors were roped in was that the process was too uncomfortable for the SS doctors. In a way, they psychologically needed some kind of scapegoat so as to cope with the stress of killing many people. At least an SS doctor would see the Jewish prisoner doctor as a kind of accomplice if not somebody wholly responsible for the killing of the prisoners (Lifton, 1986:30).

For some people it may seem to be morally unacceptable that Jewish prisoner doctors decided to be involved in the process of killing their fellow prisoners, or rather, they found themselves in a position where they had to do things they would rather not do. On the whole, Jewish prisoner doctors got involved in the selection of those to be

"euthanised" or killed because it was the morally better option. As medical doctors dedicated to saving life when it is possible to do so, it became a lesser evil for them to kill. One reason they had to kill their patients was that they themselves were in danger of death. Lifton (1986:168) records that the Jewish doctors were among the first to be targeted by the Nazis. So they had to kill in order to survive—a form of self-defence. Here the argument is that it is not normally morally acceptable for a doctor to kill a human being, but in the case when they have to choose between their own death and that of their patients or other people, the doctors would not be morally blameworthy if they chose their own life. From the doctors' point of view it is a lesser evil for them to kill patients so that they may not be killed themselves.[117]

One may argue that it may not always be the case that it is a lesser evil for the doctors to kill patients rather than die because sometimes one may determine that they cannot do certain things even if it means their own death, and killing one's patients may be such a thing. On the other hand, when a doctor in danger of being killed if he does not kill others does, it is not necessarily the lesser evil from the point of view of the one to be killed. This sometimes is not the case though when for example a patient prefers to die than to continue suffering. It may also be an objective fact that the death of a certain patient is on the whole, a lesser evil than that of a doctor.

If we grant that doctors' selection of who was to be killed is morally problematic, we may still find that it would have been worse if they did not. This is because the prisoner doctors at Auschwitz were faced with a stark dilemma. Either they refused to select prisoners who were to be killed and risk being killed themselves (the doctors); or else they refused to participate, in which case they would expose many more prisoners to death and cruel punishment. There is an example of a pregnant woman who was selected for the gas chamber. The doctor refused to send her to the gas chamber and a nurse who gave the woman a lethal injection resolved the case (Lifton, 1986:100)."Patients were further victimized by SS men and prisoner *capos* who were medically ignorant, often sadistic, and inclined to try their hand at medical procedures (a notorious former locksmith, for example, boasted of having performed many amputations)" (Lifton, 1986:214). The prisoner doctors also got involved in what may be perceived as deception of the other prisoners. Those who worked closer to the gas chambers knew when those selected were headed for the chambers that they were going to die. When asked by other prisoners what was going on, they would say that those headed for the gas chambers were going for a shower. Describing them, Lifton says that:

> these Jews engaged in this deception because they "were in a slaughter house from which there was no escape and everybody clung to his own life," and also because "it was better to save the victims from ... tortures" (the previous policy of exposing Jews to beatings, vicious dogs, and fiendish shouting); thus, "by taking over the task of the SS men, they rendered a last service to the death candidates.

[117] This could be understood to be a confusion of the principle of lesser evil and the idea of self-defence. Self-defence is when a person kills his attacker in order to stop the victim killing them; or when a person kills another in order to save his own life. The principle of lesser evil on the other hand is the idea that something that is understood to be morally wrong may be done in order to avert a morally worse one. The two are distinct, and yet I suggest that the former is an incidence or example of the latter. What I mean is that self-defence is acceptable on the basis of the principle of lesser evil. I believe that it is a lesser evil for an intended innocent victim to survive an attack than the attacker who bares moral responsibility for the attack.

This same witness went on to say that when *Sonderkommando* Jews did tell arrivals that they were going to be gassed, "they became insane, so that we later preferred to keep quiet" (Lifton, 1986:169-170). If prisoner doctors refused to participate it meant more prisoners being killed. When prisoners were ill, for example, they were killed. So when there was an epidemic the prisoner doctors who were more knowledgeable about the situation than the SS doctors because they had closer contact with the prisoner patients would hide the fact from them. This is because an epidemic or something like it meant serious consequences for the patients. For example:

As Ernst B. Explained, before mid-1942 if several cases of typhus broke out in a particular area of the camp, "it was shut off. ... All inmates were gassed (whether or not they showed signs of typhus). ... Then it was disinfected, and one hoped it would work." But Dr. B. knew that prisoner doctors used "every available means to hinder the SS doctor in recognizing ... an epidemic and hid typhus cases or falsified diagnoses" (Lifton, 1986:217).

This behaviour by the prisoner doctors resulted in saving at least those who could recover for the time they spent before being killed by the SS for some other reason. The prisoner doctors were also helpful for those destined to die because the SS sometimes misdiagnosed tuberculosis and malaria and that meant the gas chamber for the prisoner patients. So discovering that the patient suffered from a fever by the prisoner doctors saved them from certain death. In some cases the prisoner doctors deliberately falsified diagnosis so that the patients did not get gassed.

One of the difficult tasks for the prisoner doctors at Auschwitz was the selection of those to be gassed. The prisoner-doctors always made sure as few as possible prisoners were selected. They usually chose the weakest who would either die shortly from disease or those most likely to be selected by the SS for gassing because they were not strong enough to do any work. This process was always a source of worry for the prisoner doctors. They usually got the SS doctors coming in and demanding a list of those to be gassed. Every time a group of new arrivals showed up there was agony in the minds of the prisoner doctors. They faced a dilemma. The new arrivals had two routes to follow. One was straight to the gas chamber. The other was to the hospital camp (Lifton, 1986:220). This caused anxiety and ambivalence because the gas chamber was not a good prospect for the new arrivals. The camp option was both welcome in the sense that they were at least temporarily saved from imminent death and unwelcome because it meant the agonising prospect of choosing who should be gassed to give way for the newly arrived who were healthier.

The involvement of prisoner doctors in the running of the camp at Auschwitz meant that they had opportunities to do what otherwise they would not be able to do for their fellow prisoners. For example:

When Jan W., a young Polish doctor, could obtain a limited amount of invaluable typhus vaccine from his underground contacts, he did not simply dispense it on a "first come first serve" basis. He avoided giving it to inmates whom he considered "too weak to recover" or who were in general elderly and infirm (precisely the people one would give the vaccine to under ordinary circumstances), and instead chose "people who were young and who would be helped by the vaccine" (Lifton, 1986:223).

In some cases the prisoner doctors literally had to kill a fellow prisoner because it appeared to be the better or less evil option. One example is given of a prisoner leader

who murdered other prisoners. The prisoner doctors agreed and carried out a plan to kill him. Some prisoner patients posed mortal danger for other prisoners, and for the prisoner doctors, their death was a lesser evil than the alternative. This happened when one day a prisoner doctor in charge of mental patients found that:

> one of them escaped into the camp and caused a disturbance, leading the SS command to issue a warning that such things had better not happen again. Cohen's reaction, which he shared with a prisoner friend who worked with him, was that if they could not keep things quiet on the ward "we'll all be for the gas chamber." Since this mental patient was extremely difficult to control, the friend responded by questioning his "sacrificing 600 people for one lunatic!" The two cooperated in the killing by injecting an overdose of insulin, and Cohen later wrote: On that occasion ... yes, I infringed the ethical rule that one is a doctor not to murder people, but to try to keep them alive, to try to cure them, help them. ... a few weeks later, it happened again. But by that time I had far fewer moral scruples about going upstairs again and saying to V., ... "Same old thing. We'll have to do it again." And we did too, and that man died as well" (Lifton, 1986:224).

Pregnant Jewish prisoners were killed together with those who had young children. This was the case with those who got pregnant in the camp. Newly born babies were killed with their mothers. This was a problem for the prisoner doctors so they tried to at least save the mothers by either aborting the foetuses or committing infanticide after the babies were born. Some of the pregnant women refused the abortions and others agreed (Lifton, 1986:230). It was in pursuit of their medical oath that the prisoner doctors wanted to help their fellow prisoners. Adelsberger describes their situation thus:

> Medical ethics prescribe that if, during labor, the mother and the child are in danger, priority must be given to saving the life of the mother. We prisoner physicians quietly acted in accordance with this regulation. The child had to die so that the life of the mother might be saved. (Many women never got over the shock of the death of their newborn infants have forgiven neither themselves nor us.) We saved up all the poison we could find in the camp for this very purpose and it still wasn't enough. It's amazing what newborns can bear. They simply slept off otherwise lethal doses of poison, sometimes without apparent damage. We never had enough for them.
>
> One time there was no poison available, and so the mother strangled the child she had just delivered. It didn't die (Adelsberger, 1995:101).

One other case of the prisoner doctors' involvement was when they struggled to help patients recover only to have them killed following their cure because even then they were too weak to work. There were other cases of genuine research, which involved the prisoner doctors. Research into the disease noma, was authorised by the chief SS doctor, Mengele himself. It is supposed to have been carried out professionally and the patients involved were not selected for gassing. This was the case also with shock treatment for schizoid inmates, which was carried out through the advice of an inmate psychiatrist.

Generally it is said that one effect of prisoner doctors' co-operation with SS doctors was a sort of humanisation—in that they could display humane behaviour. One of the benefits was that prisoner doctors who were friendly to the SS were able to win them over so that they rarely asked them to select prisoners for gassing and they did not select from those the prisoner doctors were in charge of.

Lifton presents the evidence as supporting the view that the prisoner doctors did their best in the situation, and their involvement was a lesser evil than their non-involvement or refusal to co-operate. One important question that arises is whether the

prisoner doctors would be responsible for the resultant death and suffering of their fellow prisoners if the latter refused to co-operate with the SS. The other issue is whether or not the prisoners' human dignity was enhanced by the co-operation of the prisoner doctors with the SS. Can it ever be better for a person to be dead than to be alive? These questions are important because they can help us determine whether the prisoner doctors behaved according to the principle of lesser evil or not.

One may say that the prisoner doctors were not responsible for the arrest and ill-treatment of the Jewish prisoners. The doctors were therefore not morally responsible for what was happening to them. They were not responsible for the SS selecting who should be gassed; so the prisoner doctors had no reason to get involved. Their involvement got their hands dirty, and that was not necessary. This is supported by the fact that once they made the first move, they then went on to behave as if they had no choice but to do what they did. They were headed down a slippery slope "... a few weeks later, it happened again. But by that time I had far fewer moral scruples about going upstairs again and saying to V., ... "Same old thing. We'll have to do it again." And we did too, and that man died as well" (Lifton, 1986:224). In this example, the doctors believed that if they did not kill the troublesome prisoner, many of them would be killed.

Whilst the above argument might be correct, it does not conclusively show that the prisoner doctors should not have killed the troublesome prisoner. I argue that they were right in killing the prisoner because it was a lesser evil. We can grant that for example there is no guarantee that the fact that the SS killed Jewish prisoners before they were going to kill all of them if the troublesome one continued. So the assumption that they could all be killed as a result of the single prisoner's behaviour was unnecessary. But, given that it was highly probable that such behaviour would provoke the SS, it is not unreasonable to make that assumption. Supposing that the assumption was correct—that the prisoners would all be killed—it meant that more people would be killed than one, which was a worse evil. That is, it is morally worse to have more people (600) die than one (the sick prisoner). Even Kantians concede this (Hill, 1992:212). If on the other hand the assumption was not correct, and they went on to kill the prisoner, the prisoner doctors did not intend to kill him if there was no threat to their own survival. In this case, the moral responsibility rightly lies with the SS. It would still be more reasonable to risk the life of the one prisoner than that of the six hundred.

To the argument that as a matter of fact the prisoner doctors' cooperation with SS actually helped the latter to perpetuate the atrocities against prisoners, we may say that we do not know it for a fact.

The other issue that need attention concerning the prisoner doctors' involvement in the administration of the concentration camp is human dignity. Did they or did they not enhance the dignity of those prisoners? According to one account,

> the only thing the doctors could do for their patients, emaciated, skeletal, or swollen with the edema of starvation and wallowing in feverish deliriums as they were, was to comfort and encourage them. It didn't make them any better: they still died like flies. And again and again, rising up between the death rattles of the dying and the drawn-out moans of the critically ill was the Gypsy call: "*Mulo, mulo* [a corpse, a corpse]."
>
> The bodies were pulled out of the bunks and dragged just as they were—filthy and feces-encrusted—along the muddy corridor between the bunks and the stove toward the back of

> the block, where they were tossed into a corner. There they remained until the corpse commando came in the evening to remove the towering heaps. No pleas, no orders could bring the aides to the point of treating these cadavers with any degree of dignity. When life doesn't mean anything anymore, respect for the dead doesn't either (Adelsberger, 1995:40).

To say that the prisoners were mistreated is an understatement. It is true therefore that their dignity was undermined, violated or insulted. They underwent all sorts of humiliating experiences. Adelsberber reports that:

> My second companion contracted abdominal typhus along with her fever, complete with diarrhea and phlebitis. With legs swollen to the knee, she was unable to get to the latrine quickly enough. She was mocked not only by the Gypsy aides but also by our non-Jewish male colleague, who made fun of her with derisive verses, and she was beaten half to death. In the end she lay in her own excrement near the latrine, craving potatoes and vitamins that no one could bring her, until she, too, perished miserably (Adelsberger, 1995:51).

All these incidents occurred and would probably have occurred whether or not prisoner doctors were involved in the running of the camps. It is against such things that they are said to have worked. So one would say that if the prisoner doctors' involvement reduced the incidence of cruelty and degrading treatment of the Jewish prisoners, then they were involved in reducing evil that was occurring and it was better that they were involved than not having been involved.

Bedau has argued that "the death penalty is unquestionably the more severe punishment, no matter what a few despondent life-term prisoners or sentimental observers may think they would prefer, and no matter how painless and dignified the mode of execution might be" (Bedau, 1982:176). This was said in the context of comparing the death penalty to alternative punishment such as life imprisonment for murder. What the case of Auschwitz raises is the important question of whether it is ever better for a person to be dead than to be alive. The opponents of capital punishment routinely assume the opposite. Bedau's position may be understood to imply that being alive is always better than being dead. If that is the case, it would mean that the prisoner doctors' selection of some of the prisoners for gassing was always worse in which case it subtracted from the overall benefits from their involvement. It was never the position of the prisoner doctors that some prisoners were better off dead than alive. Only that they had to make a decision to have some killed rather than others.

If I have shown that the behaviour of prisoner doctors in the concentration camps was justified by the principle of lesser evil, it is a significant step toward showing the morality of doctors' involvement in capital punishment. The conclusion also has implications for the medicalisation of capital punishment. The implication is that if the prisoner doctors' conduct in the concentration camp demonstrates that there are times when medical involvement is justified and even morally better than non-involvement, even if such involvement may be thought to be wrong, then the medicalisation of capital punishment might be an example of such morally acceptable involvement.

APPENDIX 2

PERSONAL CORRESPONDENCE: L. HURST (1999)

13th August, 1999
Joseph,

Thank you for you e-mail. I am particularly interested in your chapter relating to the military doctor. I have found in my pilot study that there is a suggestion of moral uncase engendered by the concept of patching up casualties to fight again. This, the military nurses, find difficult to cope with, not, I think, from the viewpoint that they are in a position to kill innocent people, but that they are being placed back in a potentially life threatening environment i.e. the battle field. The relationship between nursing and war is a difficult one, as it is an antithesis of health, although the nurses consider their input to be of upmost importance and indeed to go to war without medical and nursing cover would be considered as a violation of the duty to care.

It appears from what you have written about your chapter on this subject that information may be of mutual benefit. I would like to hear a some more about the doctors role in helping to kill innocent persons -- do tell more.

I look forward to hearing from you and if you want to know more about my study, which is just about to go into the main data collection phase, please ask.

Best wishes
Lauren

25th August, 1999

Dear Joseph,

Thank you for sending the draft of your military doctors chapter. It makes interesting reading and yes there are parallels to captial punishment and there is a moral uncase related to this concept of patching casualties up to go back to the front to engage in war type activities. However, if you read Combat Surgeon it may give you an appreciation of why we need health care professionals at the front, most certainly it would be immoral to go to war without any health care at all. One might also suggest that removing health care support will not stop war, as the caring would be taken over by combat med techs/med assists -- harking back to the days of the knights, when they engaged in war during the day and cared for the injured after the days battle was over. Certainly, health care for the troops is a morale booster, they need to know that if they get injured they will be cared for. This is also more important now because of the role of the media in war -- immediacy brings the war into our front rooms. There would be a public outcry if soldiers were not treated and left to die. Certainly, from my study it is becoming quite apparent that the nurses view their role to be important and one that is integral with nursing, for their roots lie in the history of the military. They do not percieve there to be any role conflict, rather it is role tension juggling nurse and warrior in an attempt to gain a balance.

Can I advise you that the Royal Medical Corps relates to the the Army Medical Services only and should read Royal Army Medical Corps (RAMC). The Royal Air Force and Royal Navy do not come under the RAMC, they have their own branches within their single services.

I am interested to see that the doctors are expected to break patient confidentiality in terms of homosexuality. This may have been the case, although I would question their role. The military have now adopted, informally anyway, a no ask policy. As an Officer, if a person discloses they are homosexual to you, you have to report it to the authorities. I guess it only becomes a medical in confidence issue if you consider homosexuality as a medical problem. In reality, since its decriminalisation from military law, a no ask no tell policy has been adopted. Those who do disclose their sexuality usually do so because they wish to leave the military. Likewise, sexually transmitted diseases are dealt with in the same way as in civvy street. It is only disclosed when it is a notifiable disease and sexual contacts are either told by the person

involved or by the clinic. I would question the viability of your informants on these issues -- perhaps you might like to go back to them and discuss it further.

To add to the attachment you might like to get hold of a copy of the following book: Norman, R (1995) Ethics Killing and War. Cambridge University Press: Cambridge. He talks about levels of detachment from those that engage in front line combat to the detached killing associated with dropping a nuclear bomb. You may find this useful background reading.

I have also attached a further list of articles that you may find of use. If you have difficulty retrieving them, please contact me again and I will supply you with a copy.

I hope all is going well with your research. If you want to know more about my study, please do not hesitate to contact me. Good luck!!!

Best wishes

Lauren

APPENDIX 3

AMNESTY INTERNATIONAL "ETHICS OF MEDICAL PARTICIPATION IN WAR" QUESTIONNAIRE (JANUARY 25 1999)

Date: Tue, 6 Oct 1998 16:19:15 +0100
From: medical@amnesty.org
Subject: ethics of medical participation in war
To: jbrgai@essex.ac.uk
Message-ID: <80256695.004FFF6D.00@fox.amnesty.org>

Joe: see my comments below...

---------- Forwarded by Medical/I.S./Amnesty International on 06/10/98 15:29 ----------

Please respond to jbrgai@essex.ac.uk

To: Medical/I.S./Amnesty International
cc:
Subject: ethics of medical participation in war

Please, help me with your view on the following questions:

1. To what extent do you accept that medically qualified people can join the army, and if they do, they may have to kill people?

No AI policy

My view is that medically qualified people can do any job which does not conflict with their medical function. If they want to do something unethical or criminal then they should give up medicine (or preferably not do anthing unethical/criminal).

2. In your view, what comes firs in terms of ethics for a medically qualified soldier, medicine or "soldiering"?

No AI policy.

If the person is acting as a soldier then that is their priority. If they are acting as a doctor then medicine is their priority. This would be in conformity with Geneva conventions which make clear that doctors are protected under the convention when they are acting strictly as doctors.

3. In a war situation, what do you expect a medical officer to do when an enemy is firing towards the camp?

No AI policy.

I think that a doctor would be bound to prepare to treat casualties (including opponents).

4. Does a medical officer in the army have the right to carryout military planning and strategies?

No. (Apart from casualty preparedness.)

5. Why does AI not oppose the involvement of medically qualified personnel in armies?
No AI policy...But are you suggesting that wounded soldiers should not be treated?
6. Do medical personnel have other duties such as justice?

Page: 1

Mon Jan 25 16:38:26 1999
Are you talking about doctors in general? I believe so (though no AI policy on this). This has been the subject of some discussion in the *BMJ* you might want to look out for. (I think Vivienne Nathanson of the BMA wrote a piece on this subject.)

7. Do duties of justice ever come before a medical officer's medical one?
No general rule on this. As so often in ethical waters, you have to paddle around to find the optimum outcome. I certainly wouldn't rule out that a doctor's commitment to justice (and let's spend a few months defining that word) might take priority over certain clinical activities; this might be the more so if the doctor is not practising as a doctor.

Regarding the background to your query — analogies between the death penalty and military service, I would say that there are enormous problems. The doctor assisting in an execution is working for the state with the objective of extinguishing life. The condemned prisoner has no power, is not at that time a threat, and may or may not have been well served by justice.
In a war, the conflict is between military forces within which doctors are (theoretically) able to play a life-preserving, rather than life-taking role (as in the death-penalty). Doctors who fail to focus on life-preservation or healing (by, for example, undertaking military tasks) risk losing their protection under the Geneva Conventions and could be in other sorts of ethical trouble.
Good luck with the research.

I will be happy to hear from you.
May I contact you again regarding this issue?
Many thanks.

Joe Gaie

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APPENDIX 4

RESTRICTION OF DUTIES MEDICAL CERTIFICATE

RESTRICTION OF DUTIES MEDICAL CERTIFICATE

Name:	Rank:	Number:
Diagnosis:		Unit:

For _____ Days / Weeks / Months the above named:

1) Is recommended Unit Sick Leave (delete as necessary)

Is excused ALL duties at home / unit lines

2) Is FIT FOR the following	YES	NO	(tick all boxes as necessary)	YES	NO
UNIT RUNS			RANGES/WEAPONS		
UNIT PT			HEAVY WORK / LIFTING		
BFT			GUARDS		
CFT			DRIVING MIL VEH		
DRILL/MARCHES			OTHER (Specify):		
SPORTS					

Special Points / Comments:

3) Requires Appointments For: (delete as necessary)

Physiotherapy (Tel 2939) Garrison Rehab (Tel 2958) Unit QMSI / PTI Rehab

4) Fit for operational / exercise deployment as follows: (delete as necessary)

Fully in present unit role Rear Party only

In Limited Role (Specify) :

If downgraded, current medical grading = P U L PES

5) He / She is to attend for a review appointment on: _____

Signed: Date:

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